

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH			2b. HOUR	
Irvin Thomas Algire					Month <u>Feb.</u> Day <u>3</u> Year <u>1969</u>			<u>1045</u> AM	
3. SEX	4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		7. IF UNDER 1 YEAR	
Male	White		Sept. 14, 1878			90 YRS.		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			10. CITY OR TOWN OF DEATH	
Md.	USA				Carroll			Hampstead	
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		
300 N. Main St.		Farmer		Farm			Md.		
13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
Carroll		Hampstead				300 N. Main St.			
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)			
Thomas Algire			Rachel Jackson			NO			
16b. SOCIAL SECURITY NO.			17. INFORMANT Address						
219-01-4519			Mrs. Douglas Snyder Westminster, Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u>									<u>Instant</u>
4109 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebral Arterio Sclerosis</u>									<u>10 y 0</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
<u>Cerebral Arterio Sclerosis</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>Jan 27</u> , 19 <u>69</u> , to <u>Feb 3</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>Jan 27</u> , 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>M.C. Porterfield</u> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22c. DATE SIGNED <u>2-4-69</u>									
22d. PHYSICIAN'S NAME (Type) <u>M.C. Porterfield, M.D.</u> 22e. ADDRESS <u>Hampstead, Md.</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		Feb. 6, 1969		Greenmount Cemetery		Greenmount, Md.			
24. FUNERAL DIRECTOR ADDRESS				25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE			
Tipton - Eline Funeral Home Hampstead, Md.				8 1969		<u>Charles Snyder</u>			

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THE UNIVERSITY OF CHICAGO PRESS

(1)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

02231

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 15 Film 410 3/4/69 kk

CERTIFICATE OF DEATH

02227

1. DECEASED-NAME (Type or print) Lucie GREGORY And Mrs			2a. DATE OF DEATH Month Feb Day 17 Year 1969			2b. HOUR 11:30 AM					
3. SEX Female		4. RACE White		5. DATE OF BIRTH 6/20/91		6. AGE (In years lost birthday) 77 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Carroll Md.					
10. CITY OR TOWN OF DEATH MANCHESTER		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Long View Home			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife			12b. KIND OF BUSINESS OR INDUSTRY OWN HOME			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD		13b. COUNTY Carroll		13c. CITY OR TOWN New Windsor		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 208 MAIN ST			
14. FATHER'S NAME First Middle Last WM. R. Gregory			15. MOTHER'S MAIDEN NAME First Middle Last NANNIE Haskins - BAKER								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) no (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. 216-60-9046		17. INFORMANT Gerie Earle Anders Address 268 Main St, New Windsor, Md						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular Accident 4369 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) generalized arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) 5 y. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 MON											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from 12/17, 1968 , to Feb 17, 1969 , that (I) (we) last saw the deceased alive on Feb 14, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE W. H. Foard M.D DEGREE M.D ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22c. DATE SIGNED 2/17/69						
22d. PHYSICIAN'S NAME (Type) W. H. Foard M.D					22e. ADDRESS 25 N Main St, Manchester, Md 21102						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 2/20/69		23c. NAME OF CEMETERY OR CREMATORY METHODIST		23d. LOCATION (City or Town) (County) (State) UNIONTOWN MD					
24. FUNERAL DIRECTOR W. H. Foard & Sons New Windsor, Md ADDRESS					25a. REC'D BY REGISTRAR DATE FEB 20 1969		25b. REGISTRAR'S SIGNATURE Richard Judge				

FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 5 Filing 110
3/14/69 kk DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02223

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02223

1. DECEASED-NAME (Type or Print) E I I J A H First Middle Last		2a. DATE KNOWN OF ESTI-DEATH MATED <input type="checkbox"/> Feb 21 19 69 7:35 P.M.		2b. HOUR
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MAY 11, 1889	6. AGE (In years last birthday) 86 YRS.	7. IF UNDER 1 YEAR MONTHS DAYS
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
1d. CITY OR TOWN OF DEATH Sykesville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Springfield State Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Farm laborer
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland COUNTY Balto. City		13c. CITY OR TOWN Baltimore		13e. STREET AND NUMBER unknown
14. FATHER'S NAME First Middle Last HAMILTON ARNOLD		15. MOTHER'S MAIDEN NAME First Middle Last EMMA STALLINGS		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16b. SOCIAL SECURITY NO. 220-54-6645		17. INFORMANT ADDRESS Springfield State Hospital Records
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral pneumonia 4123 DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF (c) Fracture, left femur				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH days years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Schizophrenic reaction, paranoid type.				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>		21b. TIME OF INJURY Month Day, Year 5:45 P.M. 2-14-1969		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Patient fell to floor hitting buttocks. Complained of pain
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Men's Group, Springfield State Hospital, Sykesville, Carroll, Md.		21f. LOCATION Street or R.F.D. No. City or Town County State
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				
ACTUAL SIGNATURE M.C. Porter Field		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED 2/21/69
EXAMINER'S NAME (Type) M.C. PORTER FIELD		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3-6-69		23c. NAME OF CEMETERY OR CREMATORY St. Luke's Cemetery
24. FUNERAL DIRECTOR Harry W. Haight		ADDRESS Sykesville, Md.		25a. REC'D BY REGISTRAR MAR 10 1969
				25b. REGISTRAR'S SIGNATURE Charles Judge

2-55-1

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR		
WALTER BLAINE BAILE						Month Day Year			7:00 AM		
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (In years last birthday)		
Male			White			JUNE 6, 1969			84 YRS.		
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH		
Maryland			U.S.A.						CARROLL Md.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Sykesville			Springfield State Hosp.			Ret. R. R. Employee			Railroad		
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
Maryland			Carroll			Union Bridge			25 N. Main Street		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
First Middle Last			First Middle Last								
JOSEPH BAILE			LAURA FLECKINGER								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address		
no			721-18-9611-A			Springfield State Hosp. Records					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral bronchopneumonia										days	
4123 DUE TO, OR AS A CONSEQUENCE OF (b) Heart failure										days	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Arteriosclerotic heart disease										years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) phrase											
Chronic Brain Syndrome assoc. with circulatory disturbance without qualifying											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 01/20, 1969, to 02/06, 1969, that (I) (we) last saw the deceased alive on 02/06, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE										22c. DATE SIGNED	
Francisco J. Ceballos, M.D. DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>										02/06/69	
22d. PHYSICIAN'S NAME (Type) Francisco J. Ceballos, M.D.										22e. ADDRESS Springfield State Hospital	
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
BURIAL			2/4/69			PIPE CREEK			NEW WINDSOR RURAL MD		
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
A. D. Dauterive, Jr.			UNION BRIDGE MD			DATE FEB 10 1969			A. D. Dauterive, Jr.		

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VR A15
45M - 1

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
CERTIFICATE OF DEATH													
1. DECEASED-NAME (Type or print) ELVA VIRGINIA BAKER			First Middle Last			2a. DATE OF DEATH Month 2 Day 14 Year 1969			2b. HOUR 5:59 P.M.				
3. SEX Female		4. RACE White		5. DATE OF BIRTH 6-5-09			6. AGE (In years lost birthday) 59 YRS.			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN			
7a. BIRTHPLACE (State or foreign country) Virginia		7b. CITIZEN OF WHAT COUNTRY? Fredrick		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Carroll Md.						
10. CITY OR TOWN OF DEATH Skyksville			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Springfield State Hosp			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife			12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Fredrick			13c. CITY OR TOWN Fredrick			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 202 E. 4th. Street	
14. FATHER'S NAME First Ross Middle ATKINS Last ATKINS			15. MOTHER'S MAIDEN NAME First Ada Middle ATKINS Last ATKINS										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No			16b. SOCIAL SECURITY NO. ?			17. INFORMANT Records, Springfield State Hospital Address							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)													
PART 1. DEATH WAS CAUSED BY:													
IMMEDIATE CAUSE (a) Arterioscleric Heart Disease													
DUE TO, OR AS A CONSEQUENCE OF													
(b) Generalized Arteriosclerosis advanced													
DUE TO, OR AS A CONSEQUENCE OF													
(c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from Nov. 28, 1961 , to Feb. 14, 1969 , that (I) (we) last saw the deceased alive on Feb. 14, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE Francisco J. Ceballos, M.D. DEGREE						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22c. DATE SIGNED Feb. 14, 1969				
22d. PHYSICIAN'S NAME (Type) Francisco J. Ceballos, M.D.						22e. ADDRESS Springfield State Hospital							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE Feb. 17-1969			23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery			23d. LOCATION (City or Town) (County) (State) Fredrick, Md. 21701				
24. FUNERAL DIRECTOR M.R. Etchison & Son						ADDRESS Frederick, Md. 21701			25a. REC'D BY REGISTRAR FEB 18 1969 DATE				
						25b. REGISTRAR'S SIGNATURE Elwood T. [Signature]							

MEDICAL CERTIFICATION

1. The first part of the paper is devoted to a discussion of the general principles of the theory of the structure of the atom. It is shown that the structure of the atom is determined by the laws of quantum mechanics, and that the laws of quantum mechanics are in agreement with the experimental facts.

2. In the second part of the paper, the author discusses the structure of the atom in more detail. He shows that the structure of the atom is determined by the laws of quantum mechanics, and that the laws of quantum mechanics are in agreement with the experimental facts.

3. In the third part of the paper, the author discusses the structure of the atom in more detail. He shows that the structure of the atom is determined by the laws of quantum mechanics, and that the laws of quantum mechanics are in agreement with the experimental facts.

4. In the fourth part of the paper, the author discusses the structure of the atom in more detail. He shows that the structure of the atom is determined by the laws of quantum mechanics, and that the laws of quantum mechanics are in agreement with the experimental facts.

5. In the fifth part of the paper, the author discusses the structure of the atom in more detail. He shows that the structure of the atom is determined by the laws of quantum mechanics, and that the laws of quantum mechanics are in agreement with the experimental facts.

6. In the sixth part of the paper, the author discusses the structure of the atom in more detail. He shows that the structure of the atom is determined by the laws of quantum mechanics, and that the laws of quantum mechanics are in agreement with the experimental facts.

7. In the seventh part of the paper, the author discusses the structure of the atom in more detail. He shows that the structure of the atom is determined by the laws of quantum mechanics, and that the laws of quantum mechanics are in agreement with the experimental facts.

8. In the eighth part of the paper, the author discusses the structure of the atom in more detail. He shows that the structure of the atom is determined by the laws of quantum mechanics, and that the laws of quantum mechanics are in agreement with the experimental facts.

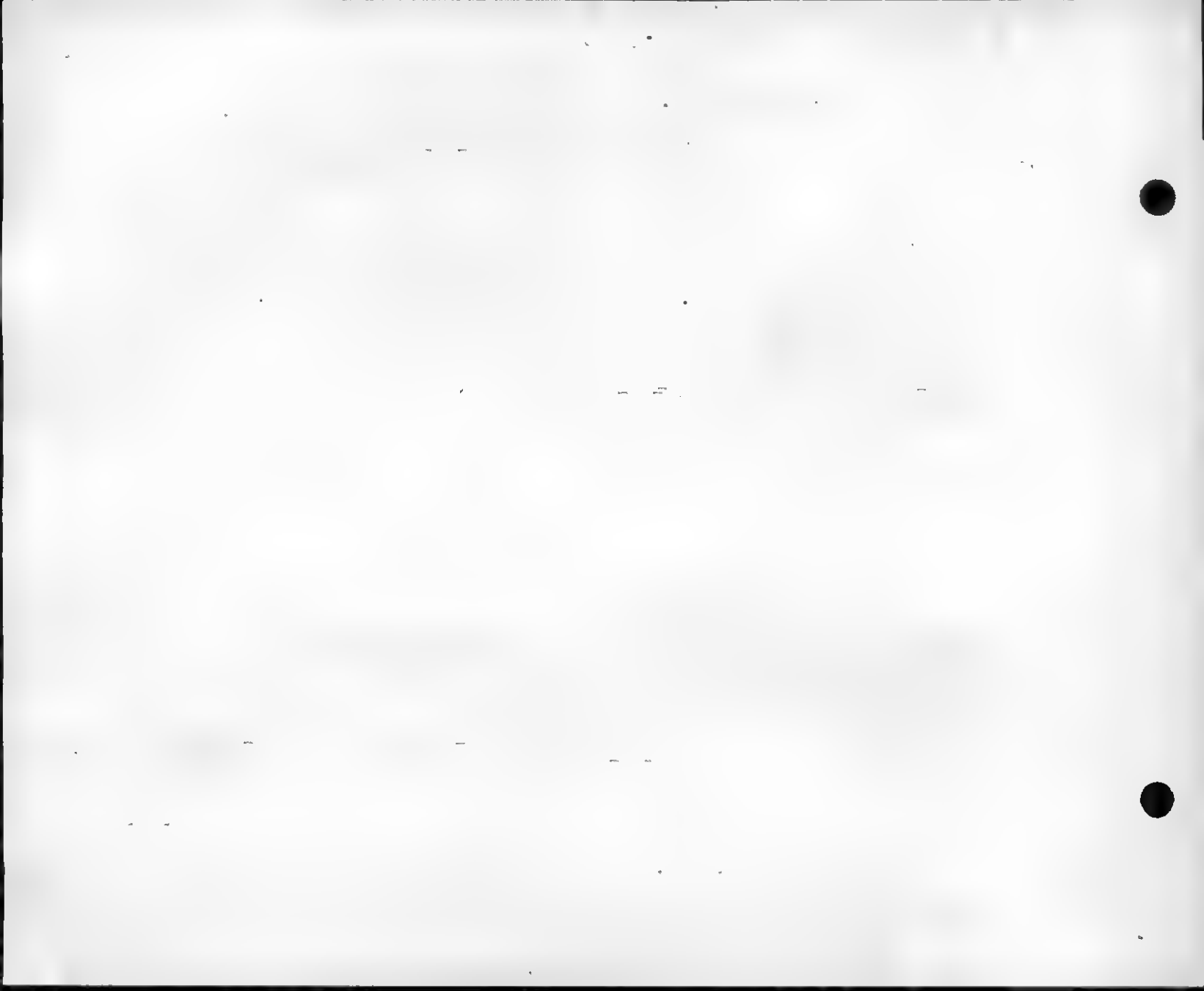
9. In the ninth part of the paper, the author discusses the structure of the atom in more detail. He shows that the structure of the atom is determined by the laws of quantum mechanics, and that the laws of quantum mechanics are in agreement with the experimental facts.

10. In the tenth part of the paper, the author discusses the structure of the atom in more detail. He shows that the structure of the atom is determined by the laws of quantum mechanics, and that the laws of quantum mechanics are in agreement with the experimental facts.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or print) ^{First} Kurt ^{Middle} Harry ^{Last} BANDEMER						2a. DATE OF DEATH ^{Month} February ^{Day} 11, 1969 ^{Year} 1969			2b. HOUR 6:30 AM		
3 SEX Male		4 RACE White		5. DATE OF BIRTH 6-14-85			6. AGE (In years last birthday) 83 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country) Germany		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Carroll County, Md.					
10. CITY OR TOWN OF DEATH Sykesville			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Springfield State Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life) Furniture Finisher			12b. KIND OF BUSINESS OR INDUSTRY Furniture		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland 17b. COUNTY Balto. City			13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 316 S. Fulton Avenue				
14 FATHER'S NAME ^{First} William ^{Middle} Bandemer ^{Last}				15. MOTHER'S MAIDEN NAME ^{First} Thelma ^{Middle} ^{Last}							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) NO				16b. SOCIAL SECURITY NO. (If yes give year or dates of service) NONE 212-01-3461		17 INFORMANT Address Records, Springfield State Hospital					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 423x Bilateral bronchopneumonia										days	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost											
DUE TO, OR AS A CONSEQUENCE OF (b) Heart failure, due to											
DUE TO, OR AS A CONSEQUENCE OF (c) Chronic adhesive pericarditis										years	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Involuntional psychotic reaction											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year 19 P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 2-6-1969, to 2-11-1969, that (I) (we) lost the deceased alive on 2-11-1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Glenn T. Sagisi						DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED 2-11-69			
22d. PHYSICIAN'S NAME (Type) Glorito Sagisi, M.D.						22e. ADDRESS Springfield State Hospital					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 2-14-69		23c. NAME OF CEMETERY OR CREMATORY Haddon Park		23d. LOCATION (City or Town) BALTIMORE		(County)		(State) Md.	
24. FUNERAL DIRECTOR Geo. E. Schwab Funeral Home 17 Francis W. Miller 2101 Frederick Ave.						25a. REC'D BY REGISTRAR DATE 13 1969		25b. REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

<div style="display: flex; justify-content: space-between;"> 02236 MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 02232 </div>											
1. DECEASED-NAME (Type or print) ELIZABETH CATHERINE BECK						2a. DATE OF DEATH Month Feb. Day 4 Year 1969			2b. HOUR 10:00 AM		
3 SEX FEMALE		4 RACE WHITE		5. DATE OF BIRTH DEC. 31, 1872			6 AGE (In years last birthday) 96		IF UNDER 1 YEAR MONTHS 96 DAYS 96		IF UNDER 24 HRS HOURS 96 MIN 96
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH CARROLL CO. Md.					
10. CITY OR TOWN OF DEATH WESTMINSTER			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 43 N. COLONIAL AVE			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) HOUSE-WIFE			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE MARYLAND			13b. COUNTY CARROLL			13c. CITY OR TOWN WESTMINSTER			13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		
13e. STREET AND NUMBER 43 N. COLONIAL AVE			14. FATHER'S NAME First THOMAS Middle SINNOTT Last SINNOTT			15. MOTHER'S MAIDEN NAME First ANNE REBECCA Middle FROCK Last FROCK					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown NO (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. 22-52-9786-3			17. INFORMANT Address SAME			17. INFORMANT Address MISS KATHERINE BECK, ADDRESS		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Upper respiratory illness 4 5X DUE TO, OR AS A CONSEQUENCE OF viral infection Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) viral infection DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 or 4 days 3 or 4 days											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR BUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. 19 Month 12 Day 1 Year 1969		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. 2/12 City or Town Westminster County Carroll State MD							
22a. I certify that (I) (this hospital) attended the deceased from 2/12 , 19 69 , to 2/18 , 19 69 , that (I) (we) last saw the deceased alive on 2/1 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Julius Chapko						DEGREE MD ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 2/6/69			
22d. PHYSICIAN'S NAME (Type) Julius Chapko						22e. ADDRESS 856 W. Green St Westminster					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 2/6/69		23c. NAME OF CEMETERY OR CREMATORY ST. JOHN'S CEMETERY		23d. LOCATION (City or Town) WESTMINSTER		23e. (County) MD		23f. (State)	
24. FUNERAL DIRECTOR R. E. - mpr - Jr, Westminster, Md.						25a. REC'D BY REGISTRAR 66B 7 1969		25b. REGISTRAR'S SIGNATURE Charles Judge			

MEDICAL CERTIFICATION



FOR STATE HEALTH DEPT.

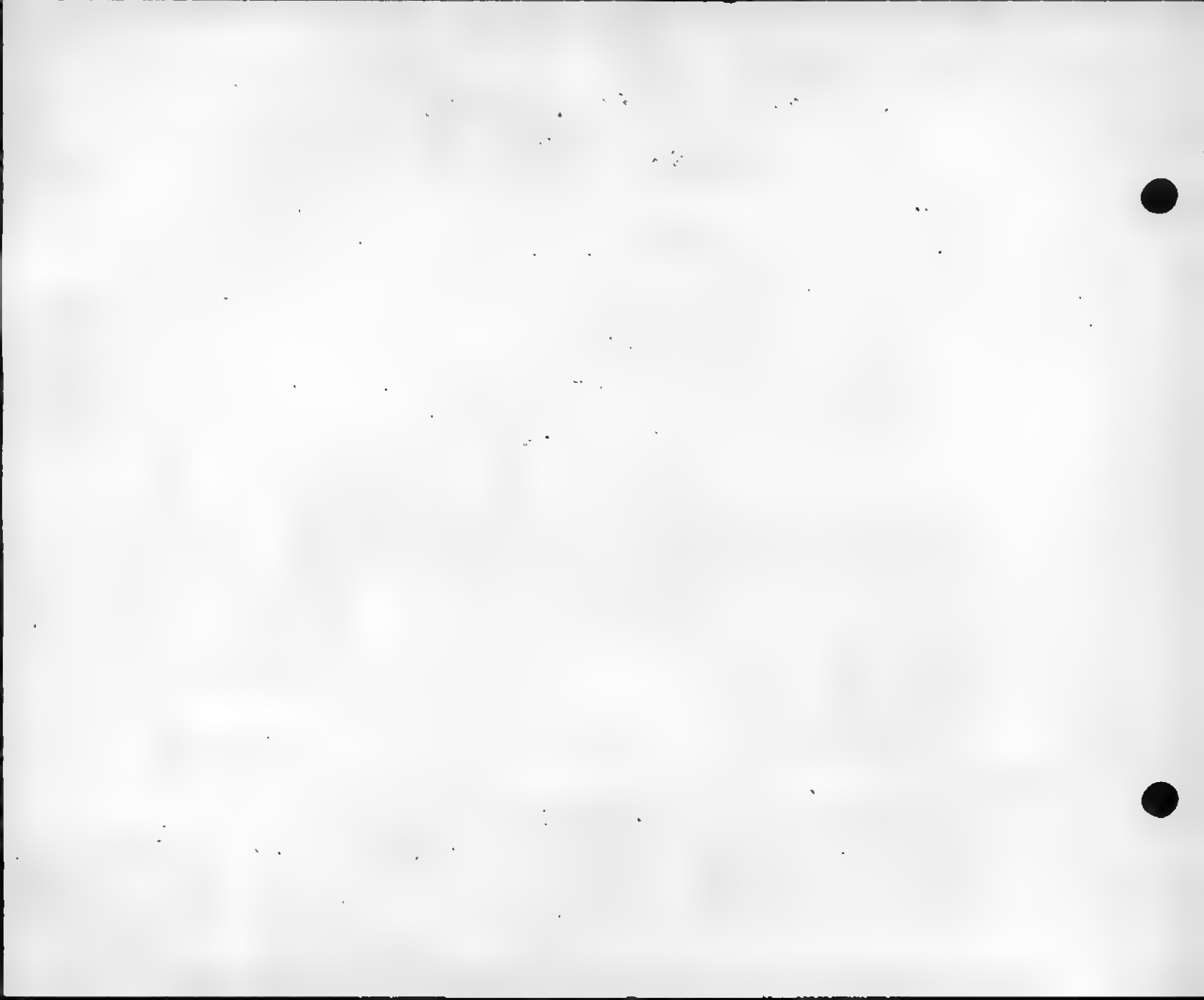
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH-1. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 1, 14, 17, 20 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02233

1. DECEASED NAME (Type or Print) WILLIAM CLINTON BOSTONIAN		2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 2-11-1969		2b. HOUR 10:45	
3. SEX M	4. RACE W	5. DATE OF BIRTH AUG 12 - 1920	6. AGE (In years last birthday) 48 YRS	7. UNDER 1 YEAR MONTHS 0 DAYS 0	8. UNDER 24 HRS HOURS 0 MIN 0
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. COUNTY OF DEATH CARROLL		12a. USUAL OCCUPATION (Kind of work done during most of work ng life, even if retired) RILN FEEDER		12b. KIND OF BUSINESS OR INDUSTRY CEMENT	
10. CITY OR TOWN OF DEATH WESTMINSTER		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) DOA CARROLL CO HOSPITAL		13a. USUAL RESIDENCE (Where deceased lived, if institution Res dence before adm ssion) MARYLAND STATE MD COUNTY FREDERICK	
13b. CITY OR TOWN JOHNSVILLE		13c. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		13d. STREET AND NUMBER NONE	
14. FATHER'S NAME: First WILLIAM Middle H Last BASTIAN		15. MOTHER'S MAIDEN NAME: First MARY Middle GRIMM Last GRIMM		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	
16b. SOCIAL SECURITY NO. 215-14-1739		17. INFORMANT Boston ADDRESS JOHNSVILLE MD		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO, OR AS A CONSEQUENCE OF Sudden (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE W Glenn Speicher		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED 2-11-69	
EXAMINER'S NAME (Type) W GLENN SPEICHER		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		ADDRESS Westminster Carroll MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE FEB 14 - 1969		23c. NAME OF CEMETERY OR CREMATORY METHODIST	
24. FUNERAL DIRECTOR D S Hartzler & Sons		ADDRESS Union Bridge		25a. REC'D BY REGISTRAR FEB 17 1969	
				25b. REGISTRAR'S SIGNATURE [Signature]	



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12
30
4
2
1

MEDICAL CERTIFICATION

VR A15 (4)
30M REV 1/68

250 REC'D BY REGISTRAR 25
DATE FEB 13 1969



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
02239 CERTIFICATE OF DEATH 02235													
1 DECEASED NAME (Type or print)			First Middle Last			2a DATE OF DEATH Month Day Year			2b HOUR				
William Thomas Brown						2 23 1969			1 AM				
3 SEX		4 RACE		5 DATE OF BIRTH			6 AGE (In years last birthday)		7 UNDER 1 YEAR		8 UNDER 24 HRS		
Male		White		8-08-89			79 YRS		MONTHS DAYS		HOURS MIN		
7a BIRTHPLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH				
Maryland			USA						Carroll			Md.	
10. CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY				
Rural			Springfield State Hosp.			Laborer/retired			Continental				
13a USUAL RES DENCE (Where deceased lived, if institution Residence before admission) STATE			13b COUNTY			13c CITY OR TOWN			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e STREET AND NUMBER	
Maryland						Baltimore			YES			5016 Edg ar Terrace	
14 FATHER'S NAME First Middle Last			15 MOTHER'S MAIDEN NAME First Middle Last										
Unknown			Unknown										
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b SOCIAL SECURITY NO.			17. INFORMANT			Address			Md.	
No			215-01-6523			Springfield State Hosp. records, Sykesville,							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))													
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Bilateral Pneumonia</u>													
4120 DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last													
(b) <u>Myocardial Infarction</u> weeks													
DUE TO, OR AS A CONSEQUENCE OF													
(c) <u>Coronary Artery Disease</u> years													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)							
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21b. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) (OFFICE BUILDING ETC)			21f LOCATION Street or RFD No City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <u>4-8-1963</u> to <u>2-23-1969</u> , that (I) (we) last saw the deceased alive on <u>2-23-1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22a. SIGNATURE <u>Gracito Patricio</u>						DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22c. DATE SIGNED <u>2/23/69</u>				
22d. PHYSICIAN'S NAME (Type) <u>Gracito Patricio</u>						22e. ADDRESS <u>Springfield State Hospital, Sykesville, Md.</u>							
23a BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE <u>2-26-69</u>			23c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn</u>			23d. LOCATION (City or Town) (County) (State) <u>Baltimore Md</u>				
23a. FUNERAL DIRECTOR <u>Funeral Home - 3218 Hudson St.</u>			ADDRESS			25a REC'D BY REG STRAR DATE <u>FEB 25 1969</u>			25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>				



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

<div style="display: flex; justify-content: space-between;"> <div> <p>02240</p> <p>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</p> <p>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</p> </div> <div> <p>02236</p> <p>02240</p> </div> </div>									
<p>1. PLACE OF DEATH</p> <p>a. COUNTY <u>CARROLL</u> MARYLAND</p> <p>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Union Mills</u></p> <p>c. LENGTH OF STAY IN 1b</p> <p>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>R # 2 Westminster, Md.</u></p>					<p>2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)</p> <p>a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u></p> <p>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Westminster (Union Mills)</u></p> <p>d. STREET ADDRESS <u>Route # 2</u></p> <p>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/></p>				
<p>3. NAME OF DECEASED (Type or print) <u>CASS</u></p> <p>First Middle Last</p>					<p>4. DATE OF DEATH <u>Feb. 19 1969</u></p> <p>Day Month Year</p>				
<p>5. SEX <u>Male</u></p>		<p>6. COLOR OR RACE <u>White</u></p>		<p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>8. DATE OF BIRTH <u>Jan. 18, 1898</u></p>		<p>9. AGE (In years last birthday) <u>71</u> yrs.</p>	
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u></p>		<p>10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u></p>		<p>11. BIRTHPLACE (State or foreign country) <u>Tennessee</u></p>		<p>12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u></p>			
<p>13. FATHER'S NAME <u>Charlie Bunch</u></p>					<p>14. MOTHER'S MAIDEN NAME <u>Emily Lou Gibson</u></p>				
<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown) <u>No</u></p>		<p>16. SOCIAL SECURITY NO. <u>414-16-3311</u></p>		<p>17. INFORMANT <u>Howard Bunch, Westminster, Maryland 21157</u></p>					
<p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]</p> <p>PART I. DEATH WAS CAUSED BY:</p> <p>IMMEDIATE CAUSE (a) <u>Cardiac Infarction</u></p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>Arterio Sclerosis C-V. Disease</u></p> <p>DUE TO (c)</p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</p>									
<p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/></p>									
<p>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</p> <p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</p> <p>20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19</p> <p>20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/></p> <p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</p> <p>20f. (City or town) (County) (State)</p>									
<p>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined manner <input type="checkbox"/></p> <p>CHIEF MEDICAL EXAMINER <input type="checkbox"/></p> <p>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/></p> <p>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/></p> <p>22. DATE SIGNED <u>Md 2-19-69</u></p>									
<p>ACTUAL SIGNATURE <u>Maurice C. Porterfield</u> M.D.</p> <p>EXAMINER'S NAME (Type) <u>M.C. PORTERFIELD</u></p> <p>Address (Street, city, town, or county) <u>HAMPSTEAD</u></p>									
<p>23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u></p>		<p>23b. DATE THEREOF <u>2/23/69</u></p>		<p>23c. NAME OF CEMETERY OR CREMATORY <u>Lady Collins Cemetery</u></p>		<p>23d. LOCATION (City, town or county) (State) <u>Sneedville, Tennessee</u></p>			
<p>24. FUNERAL DIRECTOR <u>C.O. Fuss & Son</u></p>		<p>Address <u>Taneytown, Maryland</u></p>		<p>25a. REC'D BY REGISTRAR <u>FEB 21 1969</u></p>		<p>25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u></p>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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02241

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

02237

1. DECEASED-NAME (Type or print) EMMA			First Middle Last B. COHEN			2a. DATE OF DEATH Feb Month 21 Day 1969 Year 43 00 M				
3 SEX FEMALE		4 RACE WHITE		5 DATE OF BIRTH AUGUST 5, 1910			6 AGE (In years last birthday) 58 YRS.			
7a. BIRTHPLACE (State or foreign country) BALTIMORE, MD.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH CARROLL Md.				
10. CITY OR TOWN OF DEATH WESTMINSTER			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) CARROLL COUNTY GENERAL HOSP.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY AT HOME		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND			13b. COUNTY CARROLL		13c. CITY OR TOWN WESTMINSTER		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 133 WASHINGTON ROAD	
14. FATHER'S NAME First Middle Last JOSEPH BIORSKI			15. MOTHER'S MAIDEN NAME First Middle Last FANNIE KANINSKY							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> or unknown (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17 INFORMANT MR. LOUIS COHEN, 133 WASHINGTON ROAD WESTMINSTER, MD. 21157					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac arrest										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										
(b) Diffuse vasculitis										
(c) Pericarditis nodosa										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from Dec , 19 62 to Feb 21 , 19 69 , that (I) (we) last saw the deceased alive on Feb 21 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE John S. Harshey, M.D.						DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 2/21/69		
22d. PHYSICIAN'S NAME (Type) JOHN S. HARSHEY, M.D.						22e. ADDRESS 8 Anson St. Westminster, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE 2-23-69		23c. NAME OF CEMETERY OR CREMATORY BETH JACOB			23d. LOCATION (City or Town) (County) (State) FINKSBURG, MARYLAND		
24. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD						25a. REC'D BY REGISTRAR DATE FEB 26 1969		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>		



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VR A13
30M REV.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
IDA MYERS ENGLAR						Feb. Month 22 Day 1969 Year			3:15 PM
3. SEX	4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
F	W		DEC 27 - 1868			100 YRS			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
MARYLAND		USA				CARROLL Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
MIDDLEBURG			BROOKFIELD NURSING HOME			HOUSEKEEPER		OWN HOME	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER
MARYLAND			CARROLL		UNIONTOWN		YES		NONE
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
DAVIS MYERS			REBECCA GEIMAN						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO		17. INFORMANT Address				
NO			213-12-7753		HILDA SPEICHER, UNIONTOWN MD				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) Generalized Atherosclerosis									Years
4409 DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									
(b) DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 1964, 19, to Now, 19, that (I) (we) last saw the deceased alive on Feb 21, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE J. H. CARICOFF MD						DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED Feb 22, 1969	
22d. PHYSICIAN'S NAME (Type) J. H. CARICOFF						22e. ADDRESS UNION BRIDGE MD			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
BURIAL		2/24/69		PIPE CREEK		UNIONTOWN RURAL CARROLL MD			
24. FUNERAL DIRECTOR W. D. Hartzler & Sons New Windsor						25a. REC'D BY REGISTRAR DATE FEB 25 1969		25b. REGISTRAR'S SIGNATURE J. H. JUDGE	



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VR 415
30M REV. 1-54

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
02243 CERTIFICATE OF DEATH 02239											
1 DECEASED-NAME (Type or print) Loma Lee Gist			First Middle Last			2a DATE OF DEATH Month Feb. Day 20 Year 69			2b HOUR 2:15 p.m.		
3 SEX Female			4 RACE White			5. DATE OF BIRTH 2-6-1889			6. AGE (In years last birthday) 80 YRS.		
7a. BIRTHPLACE (State or foreign country) Cambridge, Mass.			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Carroll		
10. CITY OR TOWN OF DEATH Manchester, Md.			11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Longview Nursing Home			12a USUAL OCCUPATION (Kind of work done during usual of working life, even if retired) Housewife			12b KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE md.			13b. COUNTY Carroll			13c. CITY OR TOWN Finksburg			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
13e. STREET AND NUMBER R.F.H. # 2			14. FATHER'S NAME First Middle Last Will m. Hubbard			15. MOTHER'S MAIDEN NAME First Middle Last Maria Asplen					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO			16b. SOCIAL SECURITY NO. 218-46-4884			17 INFORMANT (SON) Woodrow Gist			Address Reston, Md. R.F.D. # 3		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 4124 DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic C.V. Disease DUE TO, OR AS A CONSEQUENCE OF (c) Con'ditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 36 hrs years	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Carcinoma of left breast.											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) (OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (1) this hospital attended the deceased from Feb. 15 , 19 69 , to Feb. 20 , 19 69 , that (1) (we) last saw the deceased alive on Feb. 19 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) did (did not) view the body after death.											
22b. SIGNATURE Mamie C. Porterfield			DEGREE M.C. PORTERFIELD			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED Feb. 20, 1969		
22d. PHYSICIAN'S NAME (Type) M.C. PORTERFIELD			22e. ADDRESS HAMPSTEAD, Md								
23. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 2/24/69			23c. NAME OF CEMETERY OR CREMATORY FINKSBURG CHURCH Cem.			23d. LOCATION (City or Town) (County) (State) FINKSBURG MD.		
24. FUNERAL DIRECTOR J. E. Myers Jr.			ADDRESS Westminster, Md.			25a. RECEIVED REGISTRAR FEB 24 1969			25b. REGISTRAR'S SIGNATURE [Signature]		

MEDICAL CERTIFICATION



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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

02244

02240

1. DECEASED NAME (Type or print) <i>Estelle M. Hoanell</i>			2a. DATE OF DEATH Month <i>2</i> Day <i>26</i> Year <i>69</i>			2b. HOUR <i>4 P.M.</i>			
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>Oct. 22, 1884</i>		6. AGE (In years last birthday) <i>84</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <i>Carroll, Md.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Carroll.</i>			
10. CITY OR TOWN OF DEATH <i>Manchester, Md.</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Longview Nursing Home.</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>Md.</i>		13b. COUNTY <i>Carroll.</i>		13c. CITY OR TOWN <i>Woodbine.</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <i>Route #1 21977.</i>	
14. FATHER'S NAME First <i>Levi</i> Middle <i>D.</i> Last <i>Fryzel</i>			15. MOTHER'S MAIDEN NAME First <i>Virginia</i> Middle <i>Albert</i> Last						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <i>No.</i> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO <i>220-01-1844A</i>		17. INFORMANT Address <i>Albert Hoanell Woodbine Md. R.R. #1 (son)</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebrovascular accident</i> <i>4 hrs</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerotic Heart Disease</i> <i>3 yrs</i> DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>24 hrs</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>1/14</i> , 19 <i>68</i> , to <i>2/26</i> , 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>2/26</i> , 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>W. H. Foad</i>		22c. DATE SIGNED <i>2/26/69</i>		22d. PHYSICIAN'S NAME (Type) <i>W. H. Foad M.D.</i>		22e. ADDRESS <i>Manchester, Md 21102</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <i>3/1/1969</i>		23c. NAME OF CEMETERY <i>Ebenezer</i>		23d. LOCATION (City or Town) (County) (State) <i>Winfield, Carroll, Md.</i>			
24. FUNERAL DIRECTOR <i>C.M. Waltz, Box 241, Sykesville, Md.</i>				25a. REC'D BY REGISTRAR <i>MAR 3 1969</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

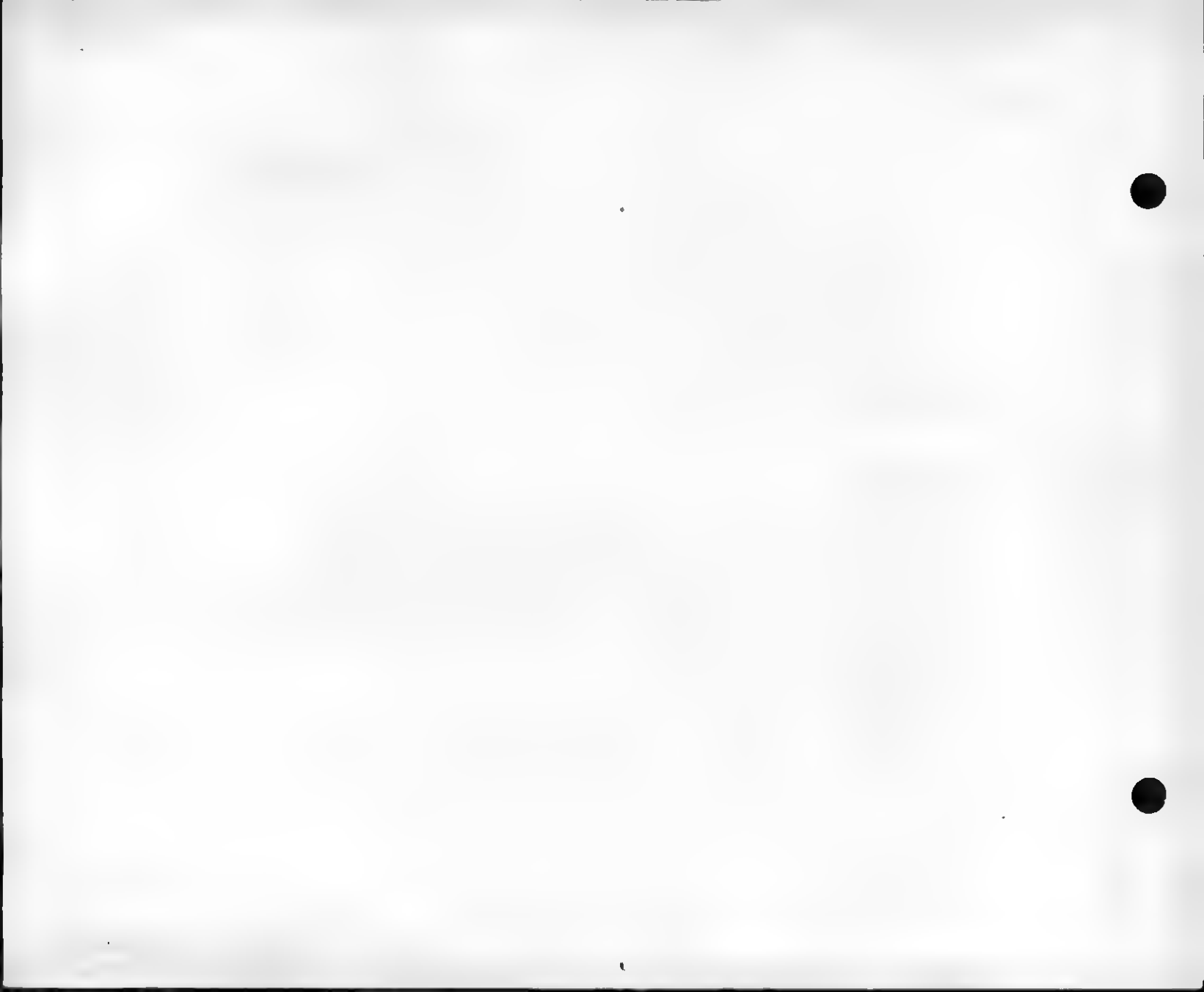


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MEDICAL CERTIFICATION

1. DECEASED-NAME (Type or print) <i>Mary</i>		First <i>Mary</i> Middle <i>—</i> Last <i>GRAVESON</i>		2a. DATE OF DEATH Month <i>Feb.</i> Day <i>2</i> Year <i>1969</i>		2b. HOUR <i>2:55 PM</i>	
3 SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>2-14-1882</i>		6 AGE (In years last birthday) <i>86</i> YRS	
7a BIRTHPLACE (State or foreign country) <i>N.Y.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <i>CARROLL</i> Md.	
10 CITY OR TOWN OF DEATH <i>Sykesville</i>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Springfield State Hosp.</i>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased lived, if institution admission) STATE <i>MARYLAND</i>		13b COUNTY <i>City</i>		13c CITY OR TOWN <i>Baltimore</i>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e STREET AND NUMBER <i>2927 Harford Rd.</i>		14 FATHER'S NAME First <i>Christian</i> Middle <i>—</i> Last <i>Johnson</i>		15 MOTHER'S MAIDEN NAME First <i>Christina</i> Middle <i>—</i> Last <i>Henson</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <i>No</i>		16b SOCIAL SECURITY NO (If yes give war or dates of service) <i>218522218T</i>		17 INFORMANT <i>Hospital Records</i>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Bronchopneumonia</i> <i>4 1/2</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Generalized arteriosclerosis.</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>—</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>COS associated with cerebral arteriosclerosis.</i>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Days.</i> <i>Year.</i>
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f LOCATION Street or R.F.D. No. City or Town County State			
22a I certify that <i>(H)</i> (this hospital) attended the deceased from <i>10-50-</i> , 19 <i>68</i> , to <i>2-2-</i> , 19 <i>69</i> , that <i>(H)</i> (we) last saw the deceased alive on <i>2-2-</i> , 19 <i>69</i> , and that in <i>(my)</i> (our) opinion death occurred on the date and hour and from the causes stated above. <i>(H)</i> (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Suha Ozgun.</i>				DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED <i>2-3-69</i>	
22d. PHYSICIAN'S NAME (Type) <i>Suha Ozgun</i>				22e. ADDRESS <i>Springfield State Hospital Sykesville Md.</i>			
23a. BURIAL, CREMATION, REMOVA. (Specify) <i>Burial</i>		23b. DATE <i>2/8/69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Sleepy Hollow</i>		23d. LOCATION (City or Town) (County) (State) <i>Tarrytown New York</i>	
24. FUNERAL DIRECTOR ADDRESS <i>Leonard J Ruck Inc Baltimore, Maryland</i>				25a. REC'D BY REGISTRAR <i>FEB 7 1969</i>		25b. REGISTRAR'S SIGNATURE <i>William Judge</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

02246

02242

1. DECEASED NAME (Type or print) DELBERT EARL GREEN			2a. DATE OF DEATH Month 7 Day 9 Year 1969			2b. HOUR 8:45 M							
3 SEX MALE		4. RACE WHITE		5. DATE OF BIRTH APRIL 7, 1886		6. AGE (In years last birthday) 82 YRS		IF UNDER 1 YEAR MONTHS 0 DAYS 0		IF UNDER 24 HRS HOURS 0 MIN 0			
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.-B.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH CARROLL CO.			Md.				
10. CITY OR TOWN OF DEATH WESTMINSTER			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) STONE ROAD			12a. USUAL OCCUPATION (Kind of work done during most of work ng life, even if retired) FARMER			12b. KIND OF BUSINESS OR INDUSTRY —				
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MARYLAND			13b. COUNTY CARROLL			13c. CITY OR TOWN WESTMINSTER			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER RFD#7 STONE RD.	
14. FATHER'S NAME First AARON Middle — Last GREEN			15. MOTHER'S MAIDEN NAME First ANNA Middle LOWE Last —										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. NONE			17. INFORMANT Address THEO. H. GREEN, SAME ADDRESS							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Chronic Uremia DUE TO, OR AS A CONSEQUENCE OF Conditions if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Instable Hypertension & Hemorrhagic cystitis DUE TO, OR AS A CONSEQUENCE OF (c) —										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4-6 months			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Chronic Bronchitis													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from Feb 8 , 19 69 , to Feb 9 , 19 69 , that (I) (we) last saw the deceased alive on Feb 9 , 19 69 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE M.C. Porterfield						DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			22c. DATE SIGNED 2-10-69				
22d. PHYSICIAN'S NAME (Type) M.C. Porterfield, M.D.						22e. ADDRESS Hampstead, Md.							
23a. BURIAL CREMATION, REMOVAL (Specify) BURIAL			23b. DATE 2/12/69			23c. NAME OF CEMETERY OR CREMATORY MT. PLEASANT CEMETERY GAMBER, CARROLL, MD.			23d. LOCATION (City or Town) (County) (State) —				
24. FUNERAL DIRECTOR J. S. Myers, Jr., Westminster, Md.						25a. REC'D BY REGISTRAR DATE FEB 13 1969			25b. REGISTRAR'S SIGNATURE Charles Judge				



CERTIFICATE OF DEATH

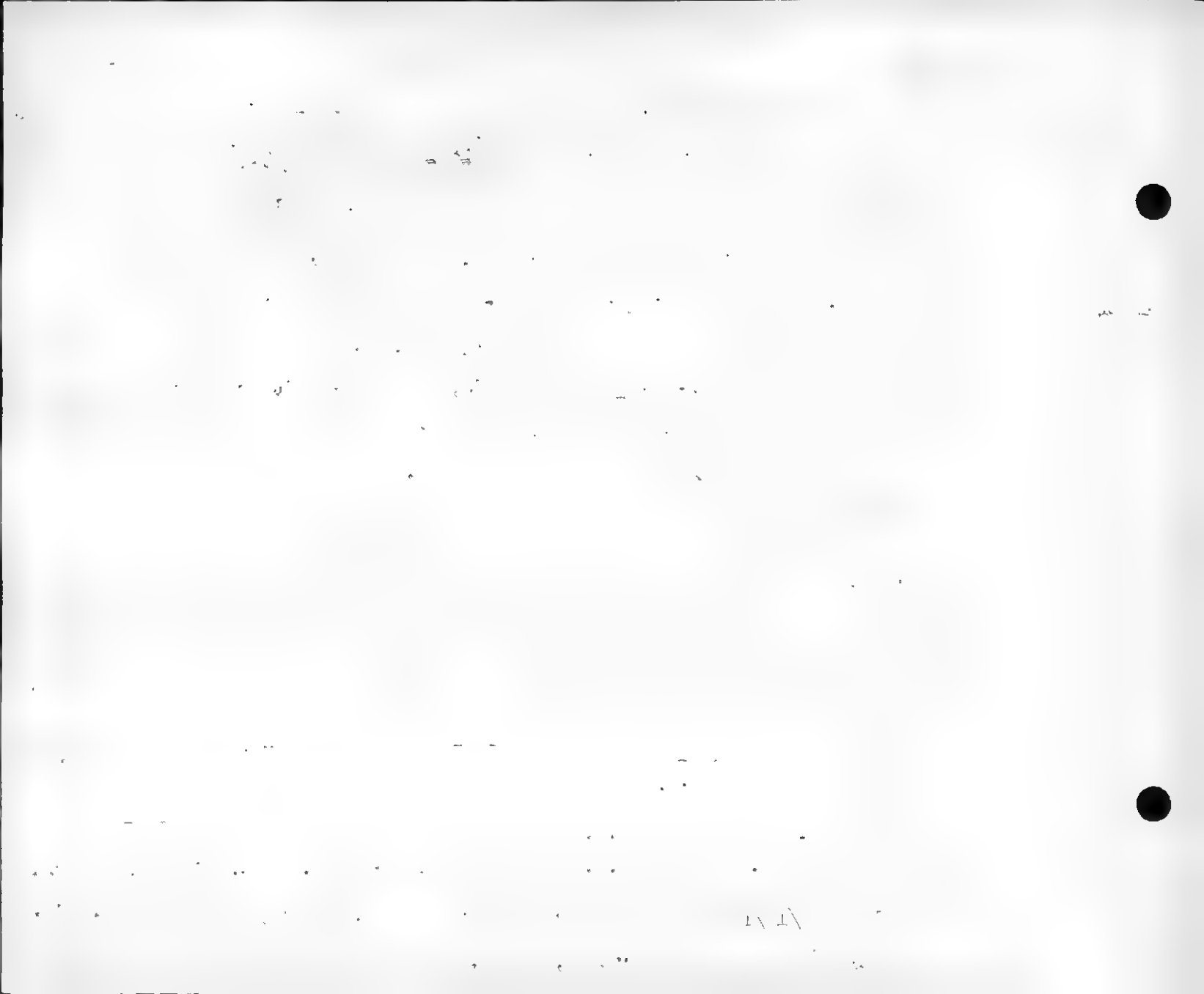
02247

02243

1. DECEASED NAME (Type or print) STANLEY AMBROSE HAHN		First Middle Last		2a. DATE OF DEATH Month Day Year 2-11-1969		2b. HOUR 5:45AM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH 11-22-1894		6. AGE (In years last birthday) 74 YRS.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Carroll Md.	
10. CITY OR TOWN OF DEATH Sykesville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Springfield State Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Electrician		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Washington		13c. CITY OR TOWN Smithsburg		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER Route 2							
14. FATHER'S NAME First Middle Last William Hahn				15. MOTHER'S MAIDEN NAME First Middle Last Hattie Wetzel			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 217-10-9527		17. INFORMANT Address Records, Springfield State Hospital			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure 4124 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Arteriosclerosis Cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Chronic Brain syndrome 206 Arteriosclerosis							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 6-21-66 , 19__, to 2-11 , 19 69 , that (I) (we) last saw the deceased alive on 2-11-69 , 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE G. Sagisi, M.D.						22c. DATE SIGNED 2-11-69	
22d. PHYSICIAN'S NAME (Type) Glocrite G. Sagisi, M.D.						22e. ADDRESS Springfield St. Hosp., Sykesville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 2/13/1969		23c. NAME OF CEMETERY OR CREMATORY Bethel Cemetery		23d. LOCATION (City or Town) (County) (State) Lantz #1, Frederick Co., Md.	
24. FUNERAL DIRECTOR Harold G. Carr				ADDRESS Waynesboro, Penna.		25a. REC'D BY REG. STRAR DATE FEB 13 1969	
25b. REGISTRAR'S SIGNATURE James Judge							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



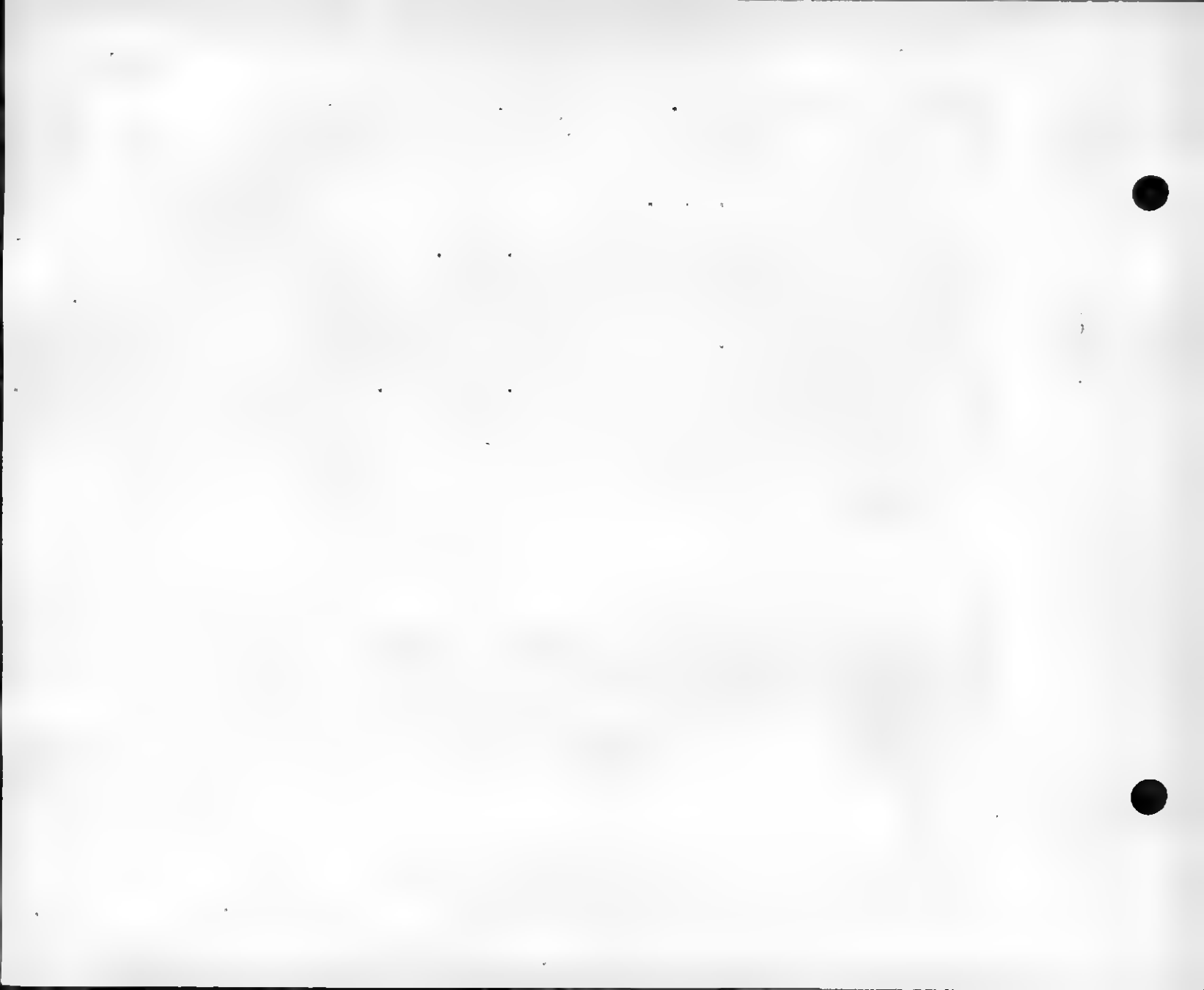
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 2 and 3, and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A 1504
30M REV 1/68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1. DECEASED NAME (Type or print) <i>Andrew B. Harryman</i>						2a. DATE OF DEATH <i>Feb</i> Month <i>14</i> Day <i>1969</i> Year			2b. HOUR <i>7:10</i> M			
3. SEX <i>FEMALE</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>February 9, 1913</i>			6. AGE (In years last birthday) <i>56</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Carroll County Md</i>						
10. CITY OR TOWN OF DEATH <i>Westminster</i>			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <i>Carroll Co. Hosp. Clarice</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY <i>Hospital</i>			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>Maryland</i>			13b. COUNTY <i>Carroll</i>		13c. CITY OR TOWN <i>Westminster</i>		13d. INSIDE CITY, W. M. T. S? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <i>RD 2 Box 354</i>		13f. <i>Westminster Md.</i>	
14. FATHER'S NAME First <i>Joshua</i> Middle <i>T.</i> Last <i>Harryman</i>				15. MOTHER'S MAIDEN NAME First <i>Mary</i> Middle <i>Feig</i> Last <i>Feig</i>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i> (If yes give war or dates of service)				16b. SOCIAL SECURITY NO		17. INFORMANT Address <i>Mr. Clifton W. Harryman 4219 Wilford Mill Rd. 21208</i>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))												
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Acute Myocardial Infarction</i>												
4109 DUE TO, OR AS A CONSEQUENCE OF (b) <i>ASCVD</i>												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING ETC		21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from <i>Sub</i> , 19 <i>67</i> , to <i>Feb</i> , 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>Feb 9</i> , 19 <i>69</i> , and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <i>Dean J. Enff M.D.</i> DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>						22c. DATE SIGNED <i>14 Feb 69</i>						
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS <i>R Ridge Rd., Westminster, Md.</i>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>2/18/69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Druid Ridge Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Pikesville, Md. Balto Co.</i>						
24. FUNERAL DIRECTOR <i>McAulley F.H.</i> ADDRESS <i>237 Patapsco Ave. 21225</i>						25a. REC'D BY REGISTRAR <i>FEB 17 1969</i> DATE		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>				

MEDICAL CERTIFICATION



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1 DECEASED-NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF ESTI-DEATH MATED			2b HOUR
Lilly (NMN) Hicks						2-26-69 19			M
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	7 UNDER 1 YEAR MONTHS DAYS	8 IF UNDER 24 HRS HOURS MIN	2c DATE PRONOUNCED DEAD Month Day Year			2d HOUR
Female	Negro	1895?	74? YRS			2- Day 26- Year 69			2:10P M
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			
Georgia		U.S.A.					Carroll County, Md.		
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY
Sykesville			Springfield State Hospital						
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b CITY OR TOWN		13c INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13d STREET AND NUMBER			
Maryland			Balto. City		Baltimore	1703 McCulloh Street			
14. FATHER'S NAME First Middle Last			15 MOTHER'S MAIDEN NAME First Middle Last						
William Williams			Elizabeth						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO		17 INFORMANT ADDRESS				
					Records, Springfield State Hospital				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia, bilateral</u>									Days
485 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
(b) DUE TO, OR AS A CONSEQUENCE OF									
(c) DUE TO, OR AS A CONSEQUENCE OF									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Fracture, right femur.</u>									
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M.		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
			19						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc)		21f LOCATION Street or R.F.D. No		City or Town		County	State
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b DATE SIGNED			
EXAMINER'S NAME (Type)			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			2-26-69			
W. Glenn Speicher, M.D.			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			135 E. Main St. Westminster Carroll			
23a BURIAL, CREMATION, REMOVAL (Specify)			23b DATE	23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town) (County)		
3/4/69				Mt Calvary Cemetery			A A County Md		
24. FUNERAL DIRECTOR ADDRESS				25a REC'D BY REGISTRAR DATE			25b REGISTRAR'S SIGNATURE		
Adolphus Holstead 1206 North Ave				FEB 28 1969			Johnas Judge		



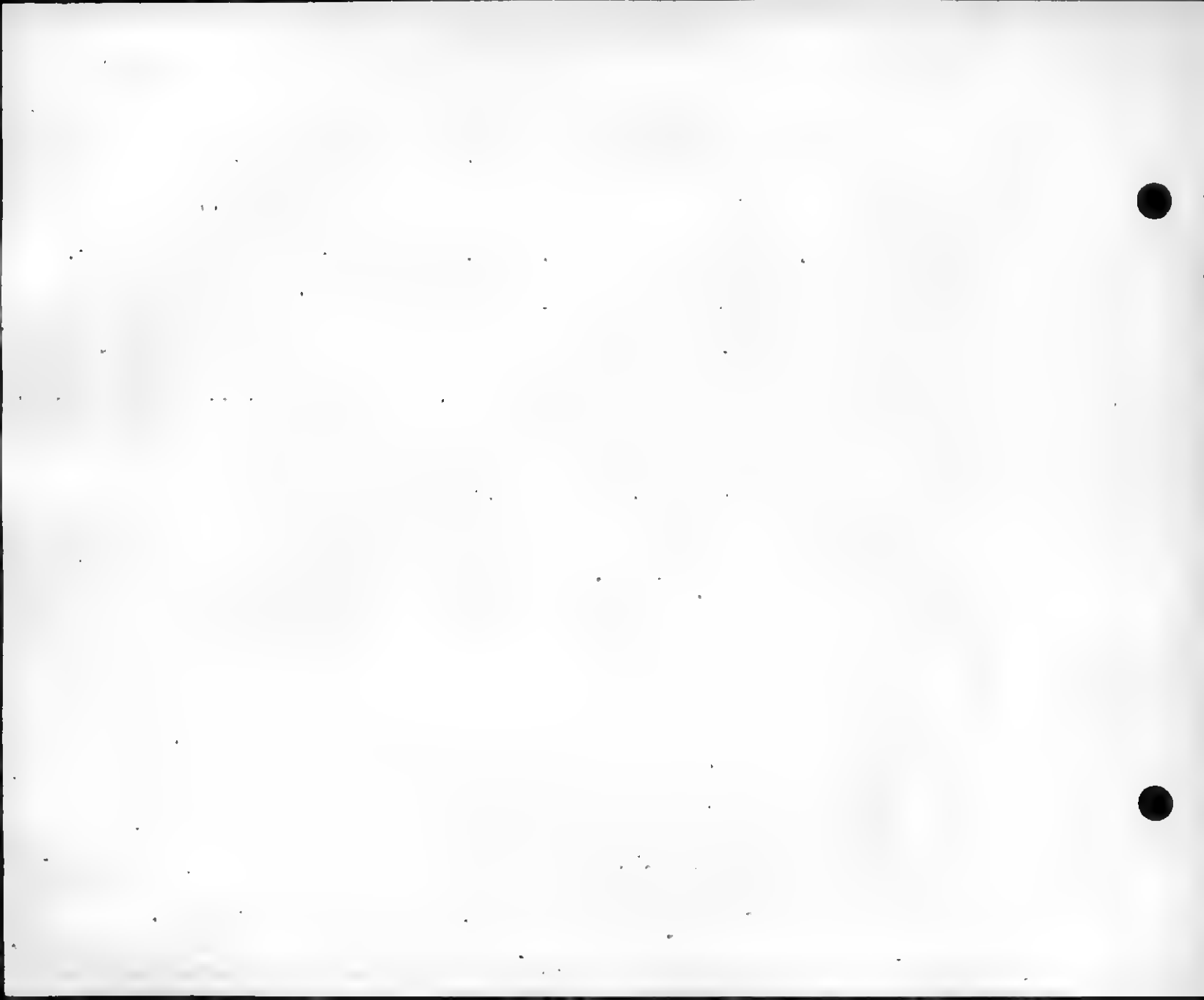
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
30M REV

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year			2b. HOUR
Frederick			NUN			Jones			2 17 69 2:10aM
3 SEX		4 RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS
Male		Negro		8-7-12			56 YRS.		IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			
Pennsylvania		USA				Carroll County Md			
10. CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Sykesville, Md.			Springfield St. Hosp.			Laborer		unk.	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Md.			Montgomery		Bethesda	YES		7010 Thor Lane	
14 FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
William unk. Evans			? ? Hughes						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)			16b. SOCIAL SECURITY NO		17 INFORMANT Address				
no			212-14-5827		Records, Springfield S.H., Sykesville, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute congestive heart failure</u>									few min.
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hypertensive cardiovascular disease</u>									
DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Chronic brain syndrome associated with central nervous system syphilis, meningococcal infection, psychotic reaction</u>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
none						YES		NO	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>May 12, 1965</u> to <u>February 17, 1969</u> , that (I) (we) last saw the deceased alive on <u>Feb. 17, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death									
22b. SIGNATURE <u>Irfan Esendal M.D.</u>						DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED 2-17-69	
22d. PHYSICIAN'S NAME (Type) <u>Irfan Esendal, M.D.</u>						22e. ADDRESS <u>Springfield State Hospital, Sykesville</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial			2-23-69		Lincoln Park.,		Rockville, Md.		
24. FUNERAL DIRECTOR <u>George R. Snowden</u>						ADDRESS <u>Rockville</u>		25a. REC'D BY REGISTRAR DATE <u>FEB 26 1969</u>	
								25b. REGISTRAR'S SIGNATURE <u>Charles J. Judge</u>	

MEDICAL CERTIFICATION



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

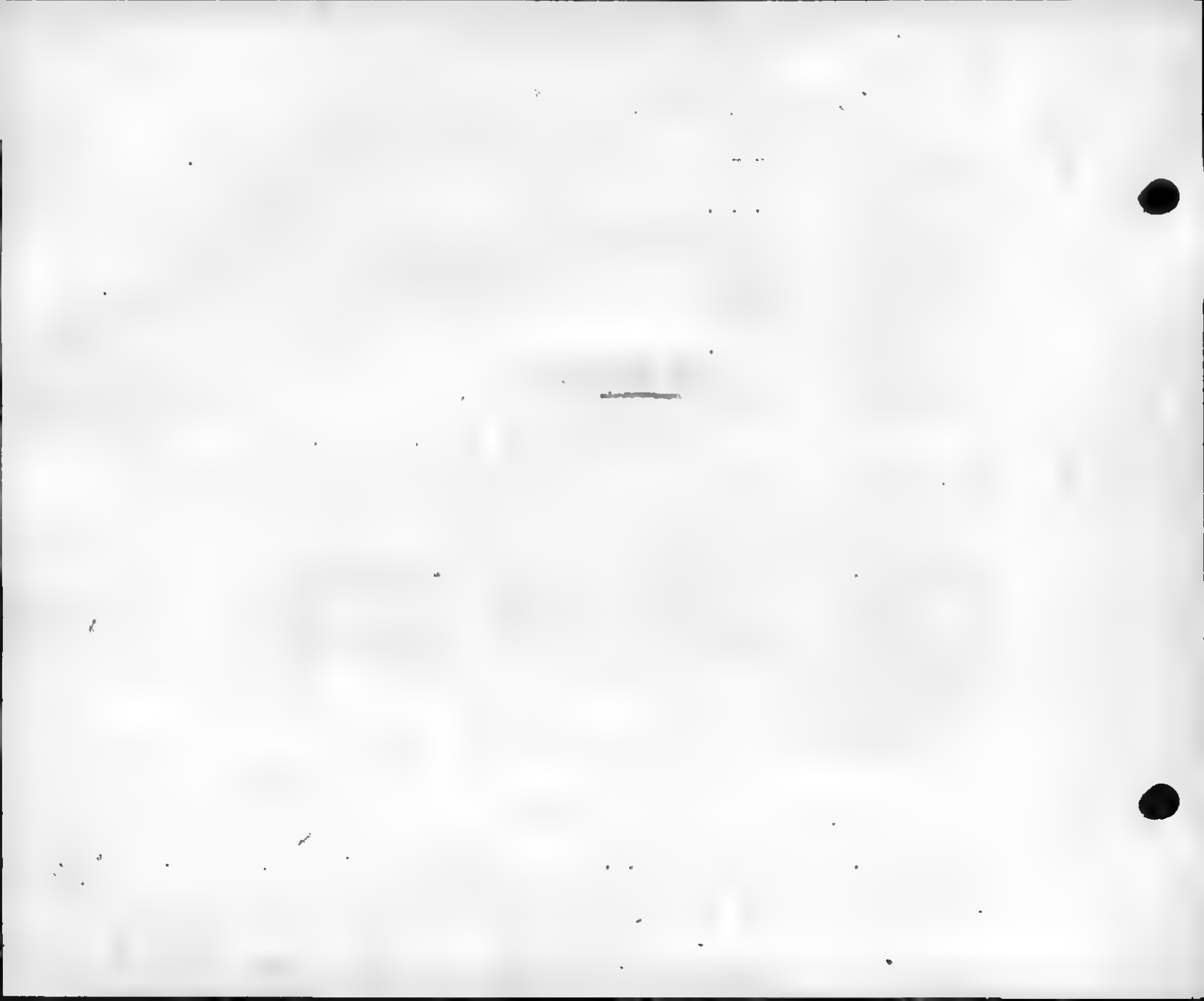
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

02251

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02247

1. DECEASED-NAME (Type or Print) JOHN MICHAEL KEMP			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month 2 Day 25 Year 1969			2b. HOUR M
3. SEX Male	4. RACE White	5. DATE OF BIRTH 6-3-49	6. AGE (In years last birthday) 19 YRS	IF UNDER 1 YEAR MONTHS DAYS 	IF UNDER 24 HRS HOURS MIN. 	2c. DATE PRONOUNCED DEAD Month February Day 25 Year 1969
7a. BIRTHPLACE (State or foreign country) Ohio	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Carroll Md			
10. CITY OR TOWN OF DEATH Sykesville	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Springfield State Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Student		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland COUNTY Washington	13b. CITY OR TOWN Hagerstown	13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 2330 Appletree Drive			
14. FATHER'S NAME First John Middle H. Last Kemp	15. MOTHER'S MAIDEN NAME First Dorothy Middle Swancott Last 					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	16b. SOCIAL SECURITY NO. 246-06-5761	17. INFORMANT ADDRESS Records, Springfield State Hospital				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Confluent bronchopneumonia, left lung and posterior part of right lung DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last 						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Days
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) CBS assoc. with convulsive disorder, with behavioral reaction						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year 19 HOUR A.M. P.M. 		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State 		
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion						
ACTUAL SIGNATURE W. Glenn Speicher		EXAMINER'S NAME (Type) W. Glenn Speicher, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MED. CAL. EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Charles Judge		22b. DATE SIGNED 2-25-69
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	23b. DATE 2/28/69	23c. NAME OF CEMETERY OR CREMATORY ROSE HILL		23d. LOCATION (City or Town) (County) HAGERSTOWN WASH.		
24. FUNERAL DIRECTOR W. T. Housmont		ADDRESS RT 45 Hwy		25a. REC'D BY REGISTRAR MAR 4 1969		25b. REGISTRAR'S SIGNATURE Charles Judge

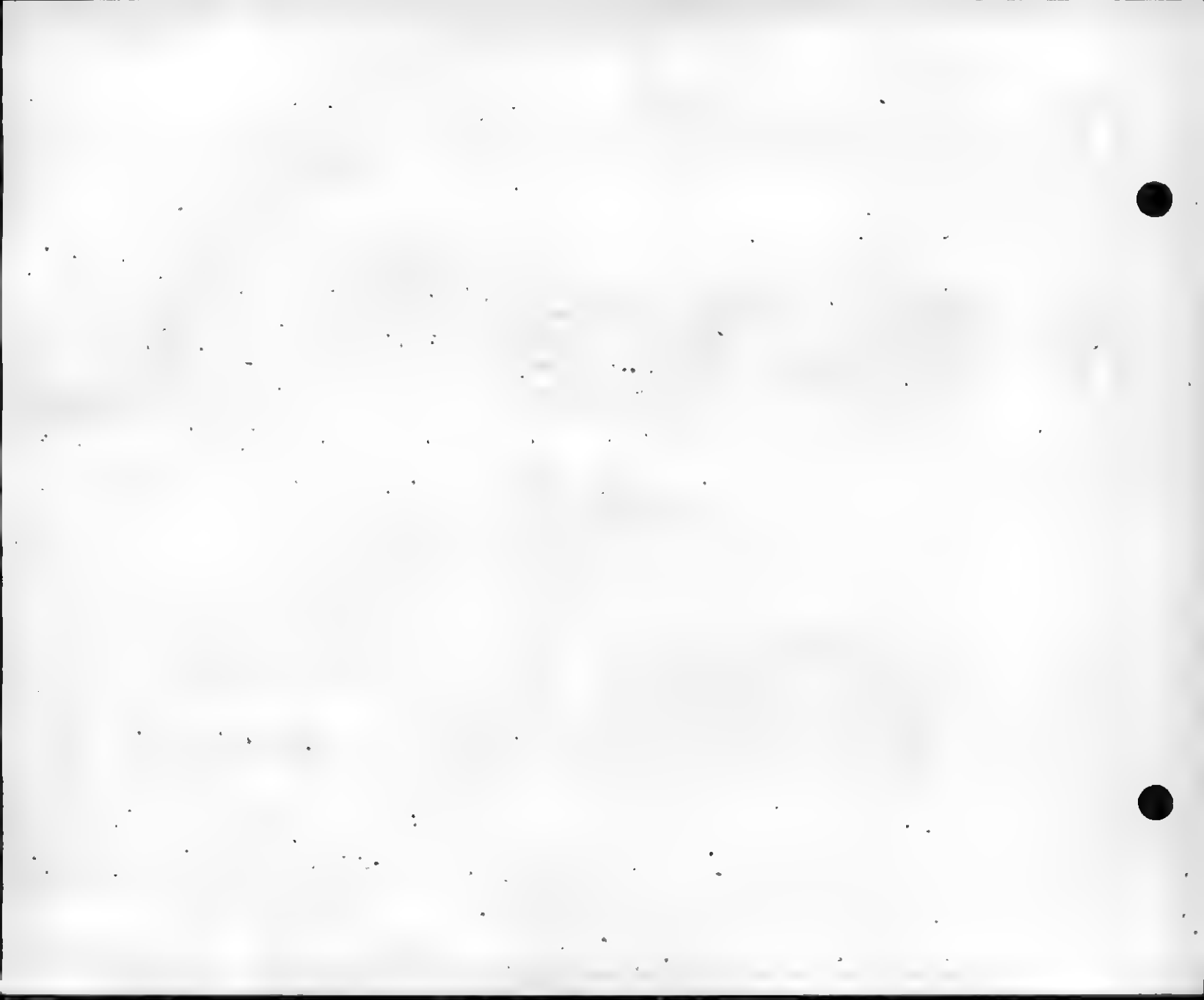


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VR A15
30M REV.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED-NAME (Type or print) First Middle Last GEORGE JOHN KREIT						2a. DATE OF DEATH Month Day Year FEB 5 1969			2b. HOUR 12:00 AM		
3 SEX MALE		4 RACE WHITE		5. DATE OF BIRTH JUNE 18 1887			6. AGE (in years last birthday) 81 YRS.		IF UNDER YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH CARROLL Md					
10. CITY OR TOWN OF DEATH RFD WESTMINSTER				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) ROUTE #7				12a. USUA. OCCUPATION (Kind of work done during most of working life, even if retired) FARMING		12b. KIND OF BUSINESS OR INDUSTRY FARM	
3a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE MARYLAND				13b. COUNTY CARROLL		13c. CITY OR TOWN WESTMINSTER		13d. INSIDE CITY LIMITS? <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER RFD #7	
14 FATHER'S NAME First Middle Last JOHN KREIT				15 MOTHER'S MA DEN NAME First Middle Last KATHERINE RAV							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown (If yes give war or dates of service) NO				16b. SOCIAL SECURITY NUMBER 212986207				16c. NAME OF NEXT OF KIN GEORGE KREIT (SON)			
				16d. ADDRESS WESTMINSTER MARYLAND				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ACUTE CONGESTIVE HEART FAILURE 9 YEARS DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) EMPHYSEMA-CHRONIC BRONCHITIS 9 YEARS DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home farm, street factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from JANUARY 61 to FEBRUARY 69 , that (I) (we) last saw the deceased alive on FEB 5 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Daniel I. Welliver M.D.						22c. DATE SIGNED 2-5-69					
22d. PHYSICIAN'S NAME (Type) DANIEL I. WELLIVER MD.						22e. ADDRESS 19 RIDGE ROAD WESTMINSTER MARYLAND					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 2/8/69			23c. NAME OF CEMETERY OR CREMATORY Parkwood Cem.			23d. LOCATION (City or Town) (County) (State) West Md		
24. FUNERAL DIRECTOR Isaac F. Luc.						25a. REC'D BY REGISTRAR FEB 6 1969			25b. REGISTRAR'S SIGNATURE William J. Judge		

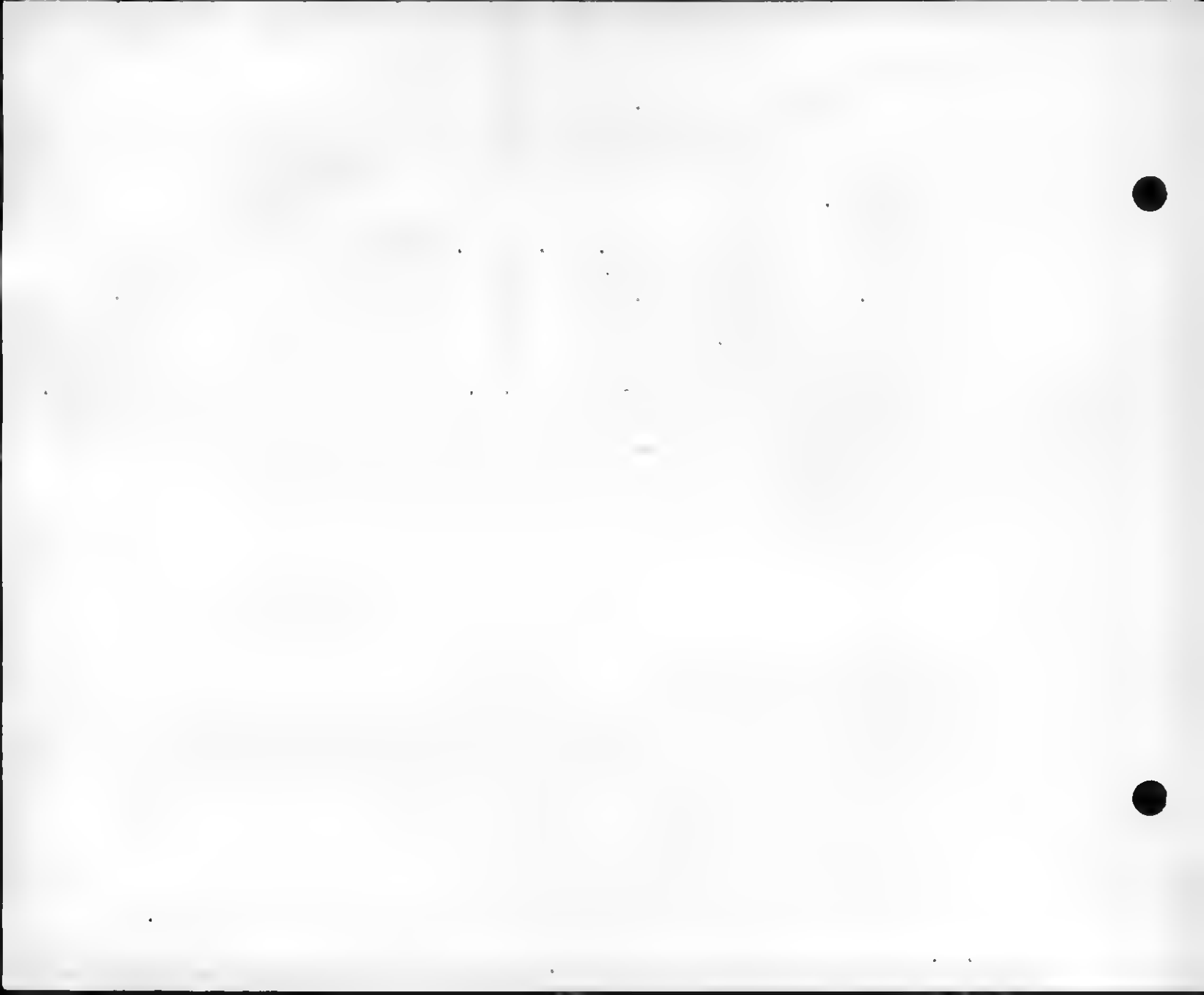


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MEDICAL CERTIFICATION

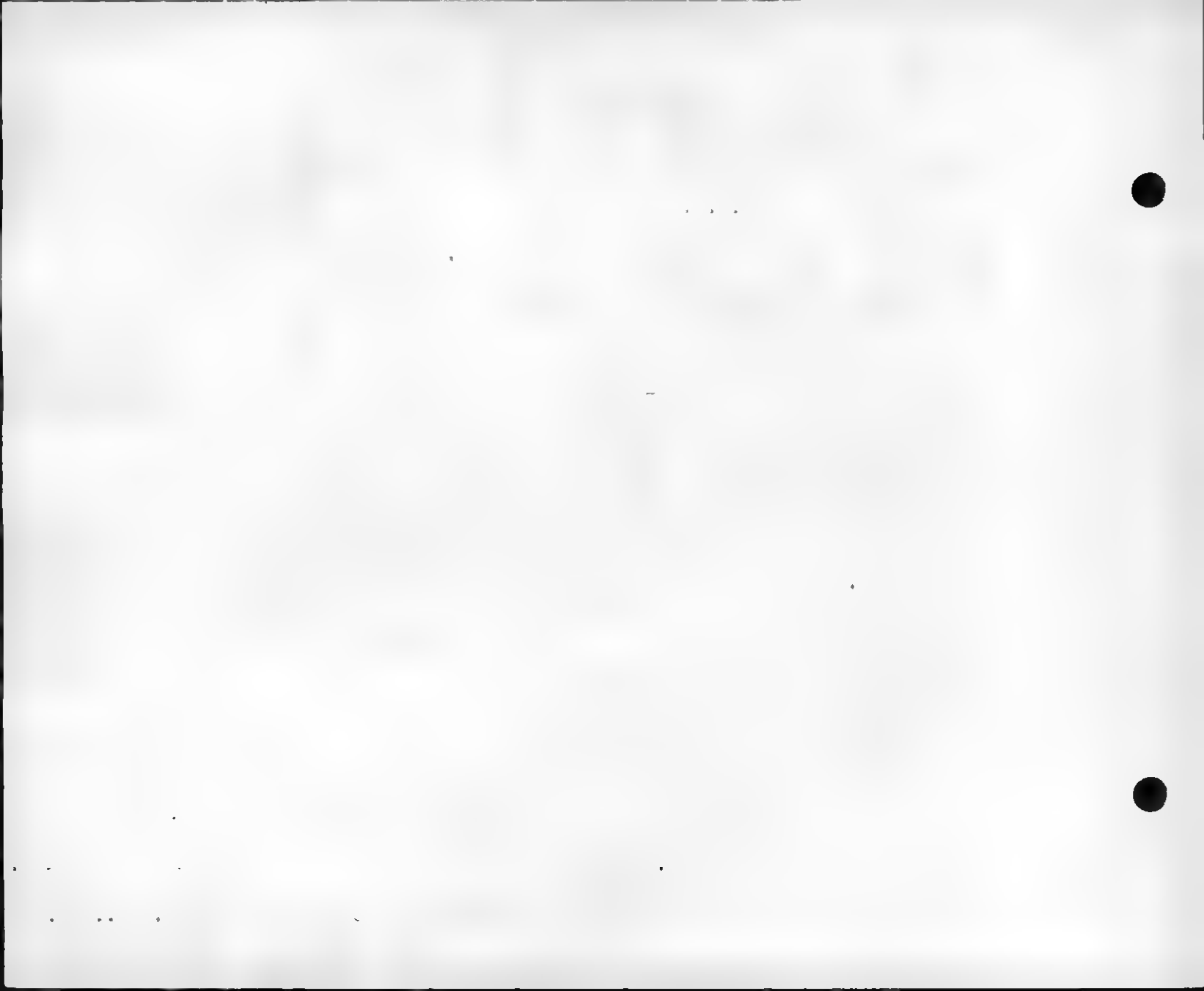
MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED NAME (Type or print) <i>Maurice D. Larkins</i>			2a. DATE OF DEATH Month <i>2</i> Day <i>15</i> Year <i>69</i>			2b. HOUR <i>4:30 PM</i>				
3. SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>March 13, 1905</i>		6. AGE (In years last birthday) <i>63</i> YRS.		IF UNDER 1 YEAR MONTHS <i></i> DAYS <i></i> HOURS <i></i> MIN. <i></i>		
7a. BIRTHPLACE (State or foreign country) <i>Balto. Co.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Carroll</i> Md.				
10. CITY OR TOWN OF DEATH <i>Westminster</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Carroll Co. Gen. Hospt.</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Supervisor at Saymore Farms</i>		12b. KIND OF BUSINESS OR INDUSTRY <i></i>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>			13b. COUNTY <i>Balto.</i>		13c. CITY OR TOWN <i>Owings Mills</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>Park Heights Ave.</i>	
14. FATHER'S NAME First <i>Charles</i> Middle <i>T.</i> Last <i>Larkins</i>			15. MOTHER'S MAIDEN NAME First <i>Carrie</i> Middle <i></i> Last <i>Belt</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> or unknown <input type="checkbox"/> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO <i>216-05-5248</i>		17. INFORMANT <i>Mr. C. William Larkins</i>				Address <i>Owings Mills, Md.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>ACUTE MYOCARDIAL INFARCTION</i> <i>4109</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>ATHEROSCLEROTIC CORONARY</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>HEART DISEASE</i>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 WEEK</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i></i>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. <i></i> Month <i></i> Day <i></i> Year <i>19</i> P.M. <i></i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. <i></i> City or Town <i></i> County <i></i> State <i></i>						
22a. I certify that (I) (this hospital) attended the deceased from <i>2/7, 1969</i> , to <i>2/15, 1969</i> , that (I) (we) last saw the deceased alive on <i>2/15, 1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>Virgil J. Brown, MD</i>					22c. DATE SIGNED <i>2/15/69</i>					
22d. PHYSICIAN'S NAME (Type) <i></i>					22e. ADDRESS <i></i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>Feb. 18, 69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Druid Ridge</i>		23d. LOCATION (City or Town) (County) (State) <i>Pikesville, Md.</i>				
24. FUNERAL DIRECTOR <i>J. F. Eline & Sons Reisterstown, Md.</i>					25a. REC'D BY REGISTRAR DATE <i>FEB 17 1969</i>		25b. REGISTRAR'S SIGNATURE <i></i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201														
CERTIFICATE OF DEATH														
1. DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR					
Raymond Benjamin Lowe						Month Day Year 2 6 69			9:05 PM					
3 SEX		4. RACE		5. DATE OF BIRTH			6 AGE (In years last birthday)		7 UNDER 1 YEAR		IF UNDER 24 HRS.			
Male		Caucasian		9-1-89			79 YRS.		MONTHS DAYS		HOURS MIN.			
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH			Md.		
Maryland			U.S.A.						Carroll					
10 CITY OR TOWN OF DEATH				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b. KIND OF BUSINESS OR INDUSTRY		
Sykesville				Springfield State Hosp.				Farmer						
13a. JS. AL RESIDENCE (Where deceased lived if institution- Residence before admission) STATE				13b. COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER				
Maryland				Washington		Keedysville				None				
14. FATHER'S NAME			First Middle Last			15 MOTHER'S MAIDEN NAME			First Middle Last					
Benjamin MNM			Lowe			Susan Elizabeth			Snyder					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16b SOCIAL SECURITY NO		17 INFORMANT						Address		
No				215-26-1295		Hospital records								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u>												days		
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Generalized arteriosclerosis</u>												years		
DUE TO, OR AS A CONSEQUENCE OF (c)														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)														
CBS assoc. with cerebral arteriosclerosis without qualifying phrase														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No			City or Town		County		State	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>6/7</u> , 19 <u>66</u> , to <u>2/6</u> , 19 <u>69</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>2/6</u> , 19 <u>69</u> , and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above, (I) <u>we</u> (did) <u>not</u> view the body after death.														
22b. SIGNATURE <u>Suha Ozgun</u>						DEGREE ATTENDING PHYS <input type="checkbox"/> MED <input type="checkbox"/> STAFF DIRECTOR <input type="checkbox"/> PHYS <input checked="" type="checkbox"/>			22c. DATE SIGNED <u>2/6/69</u>					
22d. PHYSICIAN'S NAME (Type) <u>Suha Ozgun, M.D.</u>						22e. ADDRESS <u>Springfield State Hospital, Sykesville, Md.</u>								
23a. BURIAL CREMATION REMOVAL (Specify) <u>BURIAL</u>			23b. DATE <u>2-9-69</u>			23c. NAME OF CEMETERY OR CREMATORY <u>Bakersville Cemetery</u>			23d. LOCATION (City or Town) (County) (State) <u>Bakersville, Wash. Co., Md.</u>					
24. FUNERAL DIRECTOR <u>John H. Bast, Jr</u>						ADDRESS <u>112 N. Main Street Boonshoro Md.</u>			25a. REC'D BY REGISTRAR <u>FEB 10 1969</u>			25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		



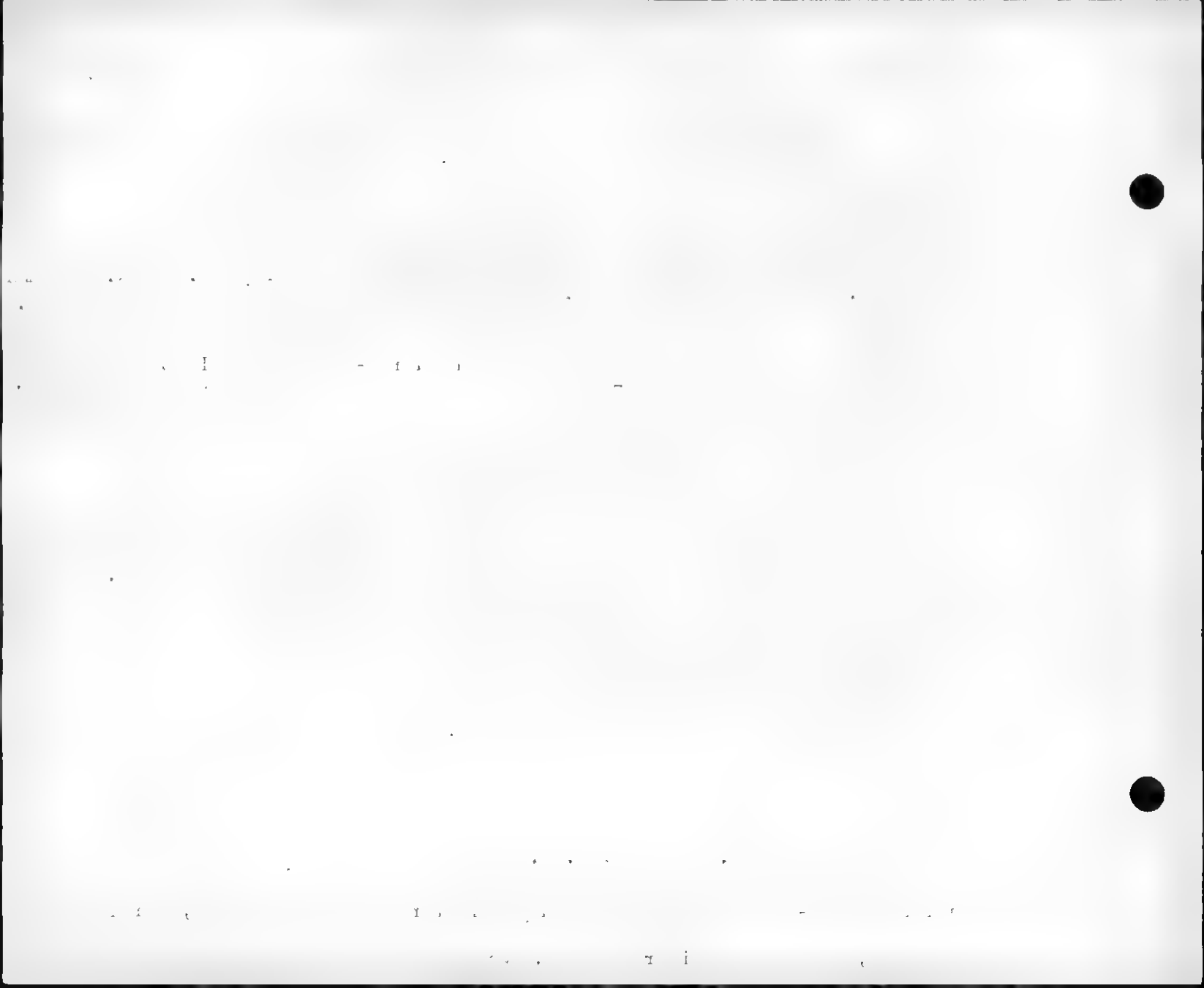
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

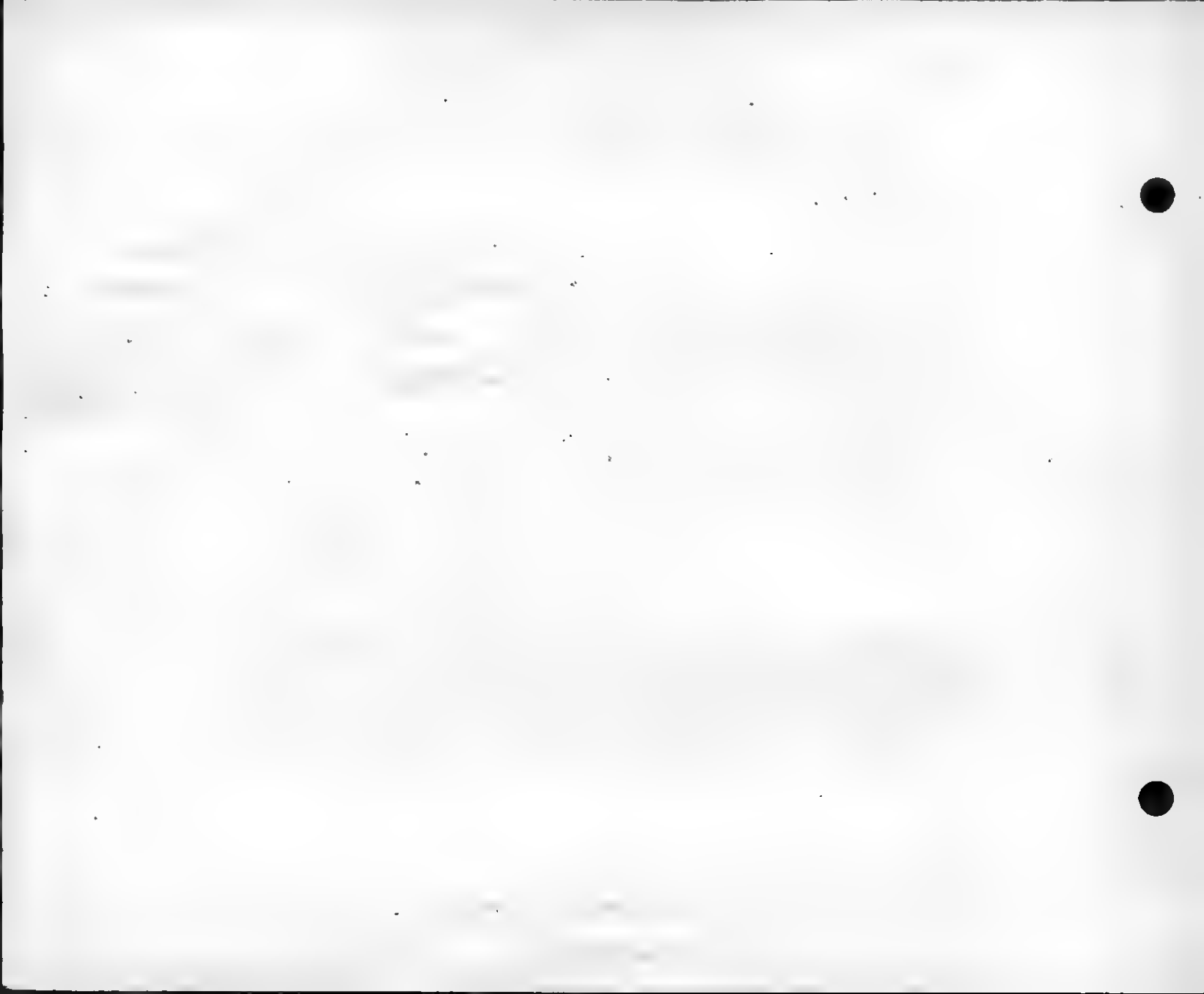
02255 Elizabeth		02251	
1. DECEASED-NAME (Type or print) First Middle Last Elizabeth Theresa Luers		2a. DATE OF DEATH Month Day Year 2 5 69	
3. SEX Female	4. RACE White	5. DATE OF BIRTH 7-26-77	
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Carroll
10. CITY OR TOWN OF DEATH Rural--Sykesville	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Springfield State Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) housewife
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE Md.	13b. COUNTY Carroll	13c. CITY OR TOWN Sykesville	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME First Middle Last Adam Buchheit	15. MOTHER'S MAIDEN NAME First Middle Last Elizabeth ? ?		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)	16b. SOCIAL SECURITY NO 218-52-0588	17. Joseph Luers - 3 Cedar Hill Road Springfield Hospital records, Sykesville, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 4123 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF (c) PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Chronic brain syndrome associated with senile brain disease without qualifying phrase.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Day Years
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or RFD No City or Town County State	
22a. I certify that (this hospital) attended the deceased from 9/29/1965, to 2/5/1969, that (we) last saw the deceased alive on 2/5/1969, and that in (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (did not) view the body after death.			
22b. SIGNATURE Francisco J. Ceballos, MD		22c. DATE SIGNED 2/5/69	
22d. PHYSICIAN'S NAME (Type) Francisco J. Ceballos, M. D.		22e. ADDRESS Springfield State Hospital Sykesville, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 2-8-69	23c. NAME OF CEMETERY OR CREMATORY Holy Family Cemetery	23d. LOCATION (City or Town) (County) (State) Randallstown, Maryland
24. FUNERAL DIRECTOR Marion Armacost-4600 Liberty Hghts. Ave		25a. REC'D BY REGISTRAR DATE FEB 11 1969	25b. REGISTRAR'S SIGNATURE Charles Judge



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give pages 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form "PM" 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			2b. H.O.J.R.
Hilda May Miller						Month Day Year			3P.M.
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (in years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD	2d. HOUR
F	W	JULY 26 1900	68 YRS.	MONTHS	DAYS	HOURS	MIN	Month Day Year	19 69 4:P.M.
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. COUNTY OF DEATH	
MARYLAND		U.S.A.		WIDOWED		DIVORCED		Carroll Md	
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hosp. to give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY
WESTMINSTER			64 So. COLONIAL AVE			OPERATOR			CLOTHING FACTORY
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE			13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?	13e. STREET AND NUMBER			
MARYLAND			CARROLL WESTMINSTER		YES	60 So COLONIAL AVE			
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			17. INFORMANT			
First Middle Last			First Middle Last			ADDRESS			
JAMES EDWARD DAVIS			MARY ELIZABETH SHUEY			THORNTON A. DAVIS SEAST CHURCH ST. FREDERICK MD.			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT				
NO			213-05-3781		THORNTON A. DAVIS SEAST CHURCH ST. FREDERICK MD.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>Cervical Thrombosis</u>									
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									
(b) <u>Arterio-sclerotic Cerebral Vascular Disease</u>									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?		
							YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18.)				
			HOUR A.M. P.M.		19				
21d. INJURY OCCURRED			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>									
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
22b. DATE SIGNED			22c. NAME OF CEMETERY OR CREMATORY						
2-18-69			MEADOW BRANCH CEMETERY WESTMINSTER, MD.						
22d. LOCATION (City or Town) (County) (State)			22e. REC'D BY REGISTRAR						
Westminster, Md.			DATE FEB 21 1969						
22f. REGISTRAR'S SIGNATURE			22g. REGISTRAR'S SIGNATURE						
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
BURIAL			2/21/69		MEADOW BRANCH CEMETERY		WESTMINSTER, MD.		
24. FUNERAL DIRECTOR			25a. REC'D BY REGISTRAR						
J. S. Moore, Jr., Westminster, Md.			DATE FEB 21 1969						



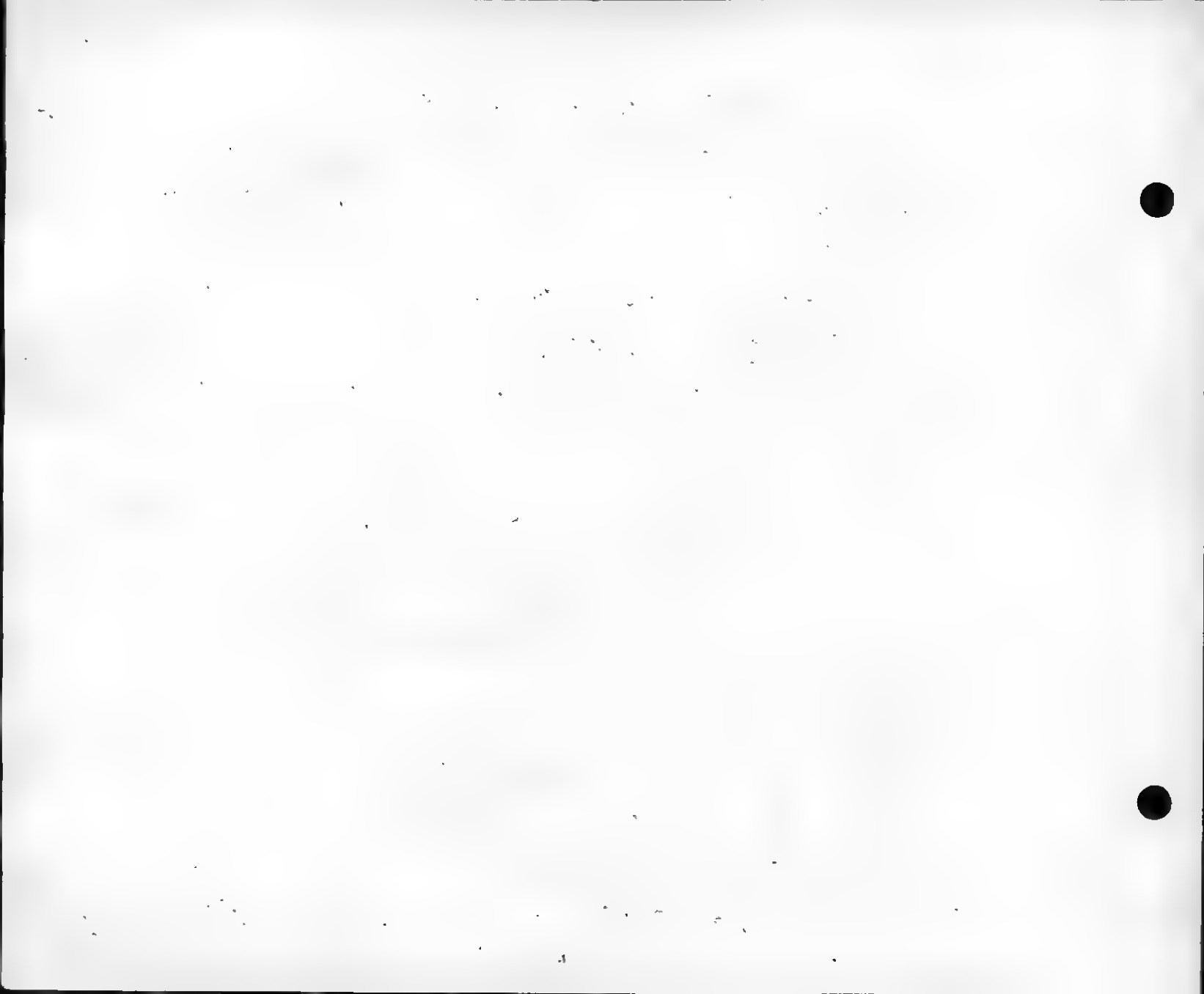
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
30M REV

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) First Middle Last WALTER WILLIAM MILLER						2a. DATE OF DEATH Month Day Year 2 23 1969			2b. HOUR 6:12 P.M.		
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH JULY 19, 1887			6. AGE (in years last birthday) 81 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH CARROLL Co. Md.					
10. CITY OR TOWN OF DEATH FINKSBURG			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) RT #1			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) FARMER			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND			13b. COUNTY CARROLL			13c. CITY OR TOWN FINKSBURG		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER RT #1	
14. FATHER'S NAME First Middle Last PETER MILLER				15. MOTHER'S MAIDEN NAME First Middle Last ?							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) NO				16b. SOCIAL SECURITY NO. 217-36-4868		17. INFORMANT Address CHAS. H. MILLER, WESTMINSTER RT #4, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) coronary occlusion 4109 DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) arteriosclerotic heart disease Approximate interval between onset and death 5 minutes noticed past year										PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) none	
19a. DATE OF OPERATION none		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED ---				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? ---			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) ---		21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year ---		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) ---							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) ---		21f. LOCATION Street or R.F.D. No. City or Town County State ---							
22a. I certify that (I) (this hospital) attended the deceased from Aug. 1, 1968 , to Feb. 23, 1969 , that (I) (we) last saw the deceased alive on Feb. 20, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE C. L. Billingslea M.D.						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 2-24-69			
22d. PHYSICIAN'S NAME (Type) C. L. Billingslea, M.D.						22e. ADDRESS Westminster, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 2/26/69		23c. NAME OF CEMETERY OR CREMATORY TRINITY LUTH. CEMETERY				23d. LOCATION (City or Town) (County) (State) FINKSBURG RD. MD			
24. FUNERAL DIRECTOR J. S. Myers, Jr. Westminster, Md.						25a. REC'D BY REGISTRAR DATE FEB 28 1969		25b. REGISTRAR'S SIGNATURE Charles Judge			

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M 1/69

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)			First		Middle		Last		2a. DATE OF DEATH Month Day Year		
ANNA			(NMN)		MORAVEC		FEBRUARY 13, 1969		7:15 A M		
3 SEX		4. RACE		5. DATE OF BIRTH			6 AGE (in years lost birthday)		7. UNDER YEAR MONTHS DAYS		
Female		White		4-20-1884			84 YRS.		IF UNDER 24 HRS. HOURS MIN		
7a BIRTHPLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Czechoslovakia			Alien				Carroll Md				
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b KIND OF BUSINESS OR INDUSTRY		
Sykesville			Springfield State Hospital			Housewife					
13a USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE			13b COUNTY		13c CITY OR TOWN		13d INS DE CITY, TOWNSHIP		13e STREET AND NUMBER		
Maryland			Montgomery		Silver Spring		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		2410 Hayden Drive		
14. FATHER'S NAME			First		Middle		Last		15 MOTHER'S MAIDEN NAME First Middle Last		
Joseph			Opocenskeho						Anna Unk.		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b SOCIAL SECURITY NO.		17. INFORMANT Address						
No			---		Records, Springfield State Hospital						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pneumonia</u>										Days	
4124 DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										Years	
(b) <u>Arteriosclerotic cardiovascular disease</u>											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
<u>Pulmonary emphysema</u>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year P.M.			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
			19								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or RFD No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>6-8-66</u> , 19 <u> </u> , to <u>2-13-69</u> , 19 <u> </u> , that (I) (we) last saw the deceased alive on <u>2-13-69</u> , 19 <u> </u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death											
22b SIGNATURE <u>Agustin del Campo, MD</u> DEGREE						22c. DATE SIGNED <u>2-13-69</u>					
22d PHYSICIAN'S NAME (Type) <u>Agustin del Campo, M.D.</u>						22e. ADDRESS <u>Springfield State Hospital Sykesville, Maryland 21784</u>					
23a BURIAL, CREMATION, REMOVAL (Specify)			23b DATE		23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town) (County) (State)			
			<u>2-17-69</u>		<u>Behrmann Nat. Cemetery</u>			<u>Sykesville Md.</u>			
24. FUNERAL DIRECTOR <u>Henry W. Haydel</u> ADDRESS <u>Sykesville Md.</u>						25a. REC'D BY REGISTRAR <u>FEB 17 1969</u>			25b REGISTRAR'S SIGNATURE <u>[Signature]</u>		



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
30M REV. 1-59

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
<div style="display: flex; justify-content: space-between;"> 02254 CERTIFICATE OF DEATH 02255 </div>									
1. DECEASED-NAME (Type or print) First Middle Last Catherine A. Mullen					2a. DATE OF DEATH Month Day Year FEBRUARY 10 1969			2b. HOUR 11 A. M.	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH DEC. 3, 1880		6. AGE (In years lost birthday) 88 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? W.I.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH CARROLL Md.			
10. CITY OR TOWN OF DEATH SYKESVILLE			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) GOLDEN AGE Conv Home			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSE WIFE		12b. KIND OF BUSINESS OR INDUSTRY	
13d. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND			13c. CITY OR TOWN DUNDALK		13e. STREET AND NUMBER 9 YORKWAY		13f. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME First Middle Last GUSTAV BROWN					15. MOTHER'S MAIDEN NAME First Middle Last ANNA E. FROST				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) NO			16b. SOCIAL SECURITY NO 212-70588D		17. INFORMANT Address JOHN R. BROWN SAME AS #13				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arterio sclerotic heart disease 4123 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Coronary artery disease DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 year ?									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from Nov. 16, 1968 to Feb 10, 1969 , that (I) (we) lost the deceased on Feb 8, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Harry Deibel M.D.					22c. DATE SIGNED 2/11/69				
22d. PHYSICIAN'S NAME (Type) Harry Deibel M.D.					22e. ADDRESS 1226 S. Hanover Street				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE FEB. 13, 1969		23c. NAME OF CEMETERY OR CREMATORY LOUDON PARK CEMETERY		23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND			
24. FUNERAL DIRECTOR WALTER BROOKS BRADLEY, INC., DUNDALK, MD.					25a. REC'D BY REGISTRAR DATE FEB 13 1969		25b. REGISTRAR'S SIGNATURE W. Brooks Bradley		

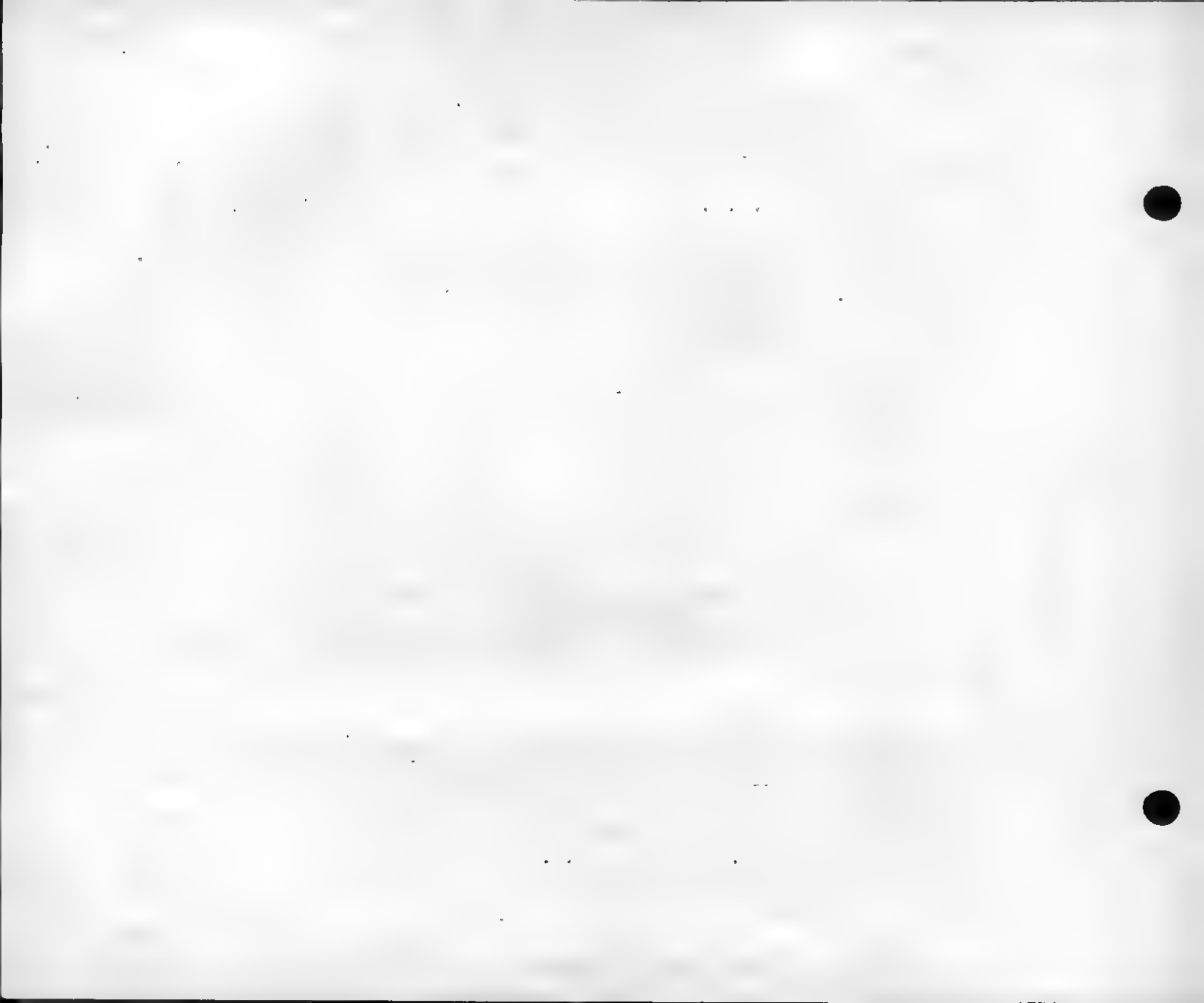
MEDICAL CERTIFICATION



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
MEDICAL EXAMINER'S CERTIFICATE OF DEATH												
1. DECEASED-NAME (Type or Print)			First <u>LEWIS</u>	Middle <u>LOUIS</u>	Last <u>MUNCH</u>	2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 2/19 1969 DEATH MATED <input type="checkbox"/>		Month 2	Day 19	Year 1969	2b. HOUR M	
3. SEX Male	4. RACE White	5. DATE OF BIRTH Aug. 25, 1912	6. AGE (In years last birthday) 56 YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c. DATE PRONOUNCED DEAD Month February		Day 19	Year 1969	2d. HOUR P. M.
7a. BIRTHPLACE (State or foreign country) W. Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH CARROLL Md.						
10. CITY OR TOWN OF DEATH Westminster			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Manchester Avenue			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Restaurant owner & operator			12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.			13b. COUNTY CARROLL		13c. CITY OR TOWN Westminster		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 184 William Avenue			
14. FATHER'S NAME First Edgar			Middle Eldon			Last Munch			15. MOTHER'S MAIDEN NAME First Elizabeth			Middle Dent
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no			16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 234-01-1938			17. INFORMANT ADDRESS William Ave. Mrs. Charlotte S. Munch, Westminster, Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Hypertensive and arteriosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No			City or Town		County	State
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE <u>Charles S. Springate</u> EXAMINER'S NAME (Type) Charles S. Springate, M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED February 20, 1969
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE 2/24/69		23c. NAME OF CEMETERY OR CREMATORY Lake View Mem. Park			23d. LOCATION (City or Town) Sykesville, RD.			(County) Md.	(State)
24. FUNERAL DIRECTOR <u>E. E. Myers, Jr., Westminster, Md.</u>						25a. REC'D BY REGISTRAR FEB 24 1969		25b. REGISTRAR'S SIGNATURE <u>Charles S. Springate</u>				



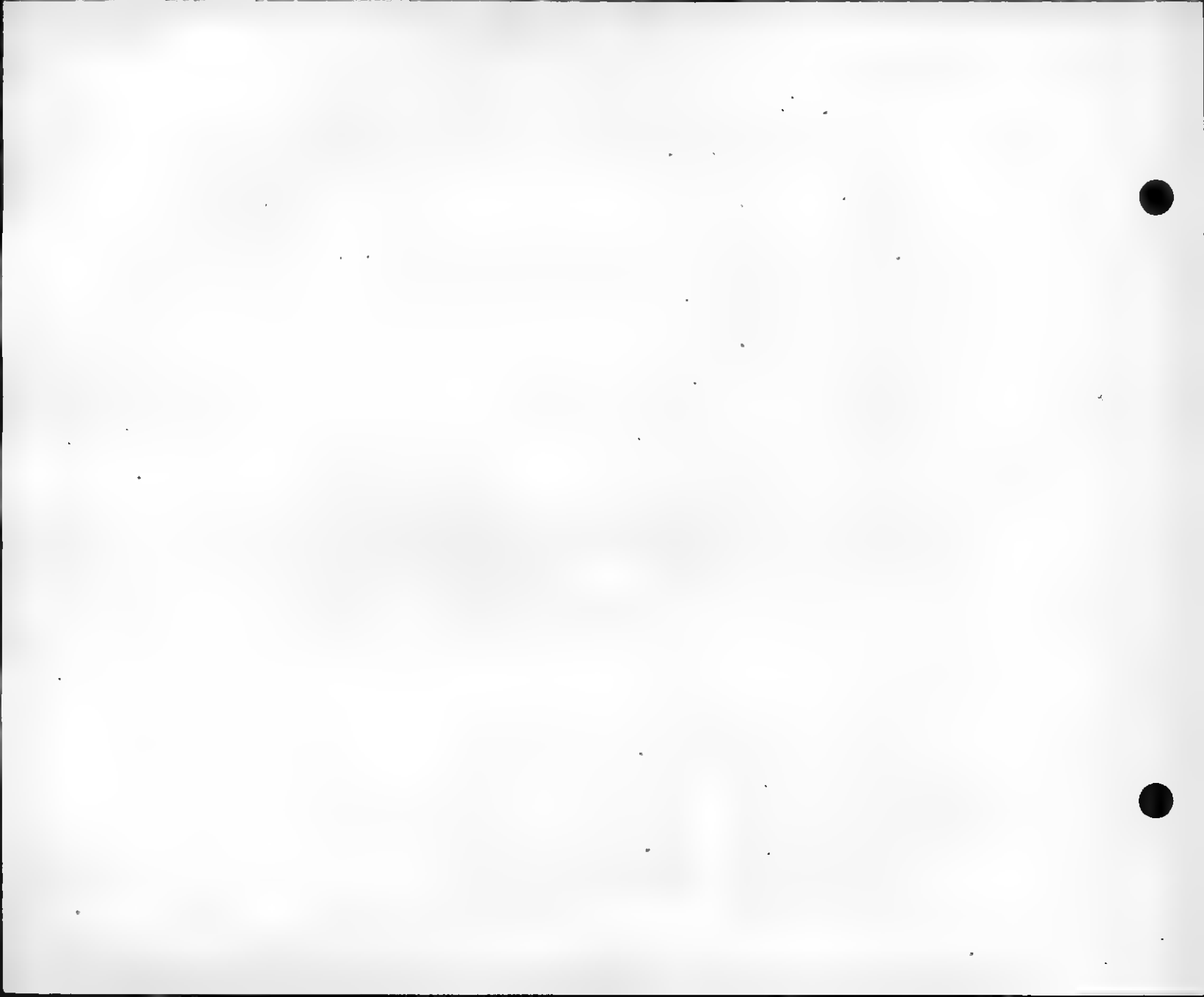
FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. The pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or Print) VICTOR C. MYERS			2a DATE KNOWN OF ESTI-DEATH MATED <input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year 1969 4 30 PM			2b HOUR			
3 SEX M	4 RACE Colored	5 DATE OF BIRTH Oct. 12, 1900	6 AGE (in years last birthday) 68 YRS.	7 UNDER YEAR MONTHS 14	8 UNDER 24 HRS. DAYS 16	2c DATE PRONOUNCED DEAD Feb. 16		2d HOUR 1969 8:55 PM	
7a BIRTHPLACE (State or foreign country) Maryland		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH CARROLL			
10 CITY OR TOWN OF DEATH Mt. Airy			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Route 2			12a USCA. OCCUPATION (Kind of work done during most of working life, even if retired) Laborer		12b KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased lived, if not institution: Residence before admission) STATE Maryland			13b COUNTY Carroll		13c CITY OR TOWN Mt. Airy		13d INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		13e STREET AND NUMBER Route 2
14. FATHER'S NAME First Charles R. Myers Middle Last 				15 MOTHER'S MAIDEN NAME First Martha Middle Last Smith					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16b SOCIAL SECURITY NO. 578-18-6683		17. INFORMANT ADDRESS Mrs. Mary Simms Same As Above				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Chronic Myocarditis DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) storing the underlying cause last. (b) Pulmonary Fibrosis DUE TO, OR AS A CONSEQUENCE OF (c) 									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3-4 weeks 8 months
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b TIME OF INJURY Month, Day, Year HOJR A.M. 19 P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No		City or Town		County	State
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE M.C. Porterfield			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b DATE SIGNED 2-16-69			
EXAMINER'S NAME (Type) M.C. PORTERFIELD			M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
ADDRESS (Street, city, town, or county) HAMPSTEAD, Md									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE 2/19/1969		23c NAME OF CEMETERY OR CREMATORY Woodville Cemetery		23d LOCATION (City or Town) Frederick Co., Md.		(County) (State)	
24 FUNERAL DIRECTOR C.M. Waltz, Box 241, Sykesville, Md.				25a REC'D BY REGISTRAR FEB 19 1969		25b REGISTRAR'S SIGNATURE 			

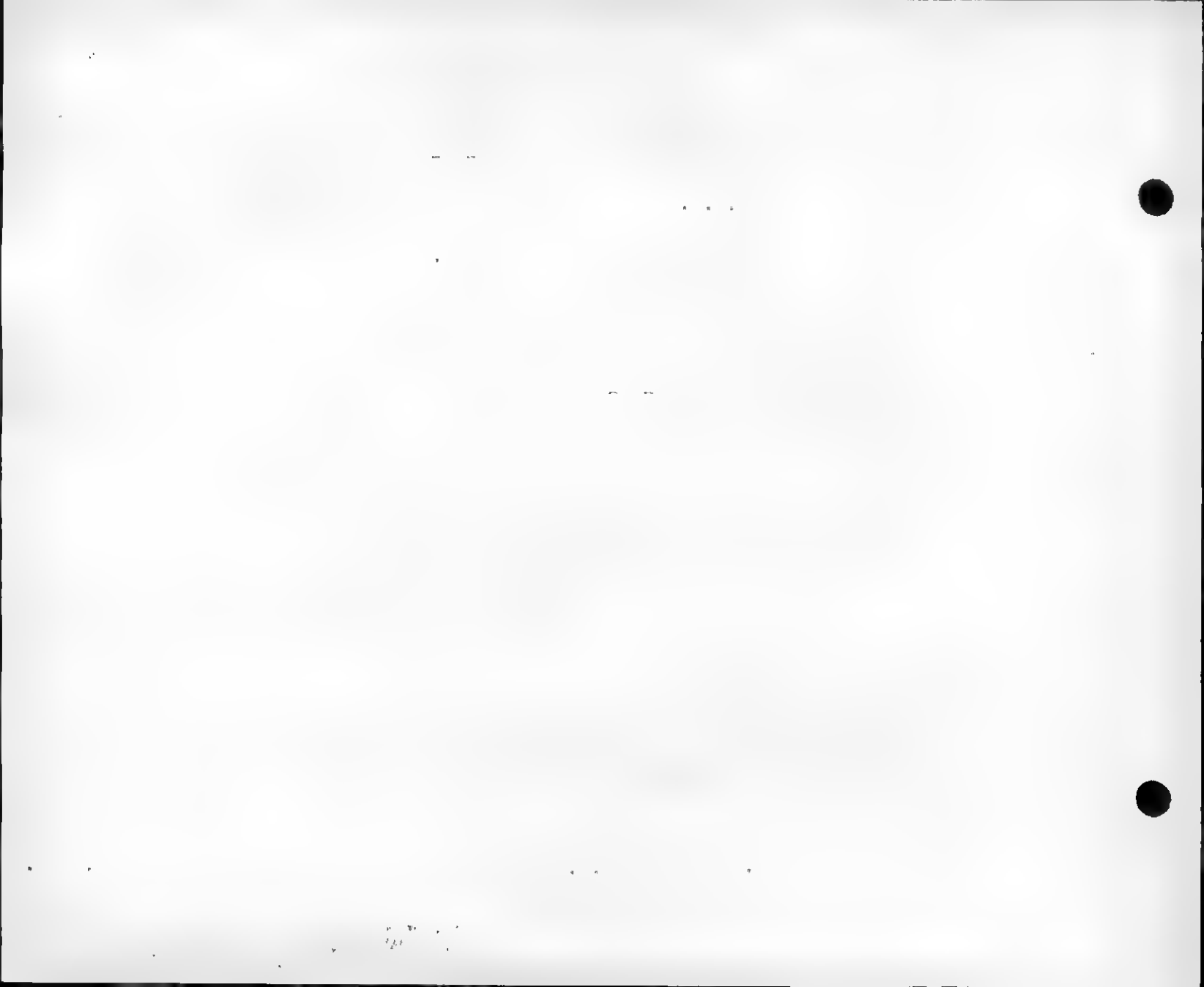


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers' Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
45M - 1

MIDDLE											
1. DECEASED-NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH		2b. HOUR	
Bruce		Norman		Nicola				Month 2 Day 22 Year 69		2:30 A.M.	
3 SEX		4. RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Male		Caucasian		2-26-1875		93 YRS.		MONTHS DAYS		HOURS M.N.	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH					
Pennsylvania		U.S.A.				Carroll				Md	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY					
Sykesville		Springfield State Hosp.		laborer		unknown					
13a USUAL RESIDENCE (Where deceased lived, if institut on. Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIM 15?		13e STREET AND NUMBER			
Maryland		Allegany		Westernport		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		319 Vine Street			
14. FATHER'S NAME		First		Middle		Last		15 MOTHER'S MAIDEN NAME		First Middle Last	
unknown								unknown			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)		16b. SOCIAL SECURITY NO		17 INFORMANT		Address					
no		213-24-5942		Hospital Records							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pneumonia, bilateral</u>											
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Pulmonary Emphysema</u>											
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerotic Heart Disease</u>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
		HOUR A.M. Month Day Year P.M. 19									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No		City or Town		County State	
22a I certify that (he) (this hospital) attended the deceased from <u>7/28</u> , 19 <u>67</u> , to <u>2/22</u> , 19 <u>69</u> , that (he) (we) last saw the deceased alive on <u>2/22</u> , 19 <u>69</u> , and that in (our) (our) opinion death occurred on the date and hour and from the -causes stated above, (he) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS		22e. DATE SIGNED					
<u>Frank V. Patricio</u>		Gracito T. Patricio, M.D.		Springfield State Hospital, Sykesv., Md.		2-22/69					
23a BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)	
Burial		Feb. 25, 1969		Philos Cemetery		Westernport		Allegany		Md.	
24 FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
<u>W. Harold Fredlock</u>		<u>Bedmont, W. Va.</u>		DATE FEB 26 1969		<u>Charles Judge</u>					



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MEDICAL CERTIFICATION

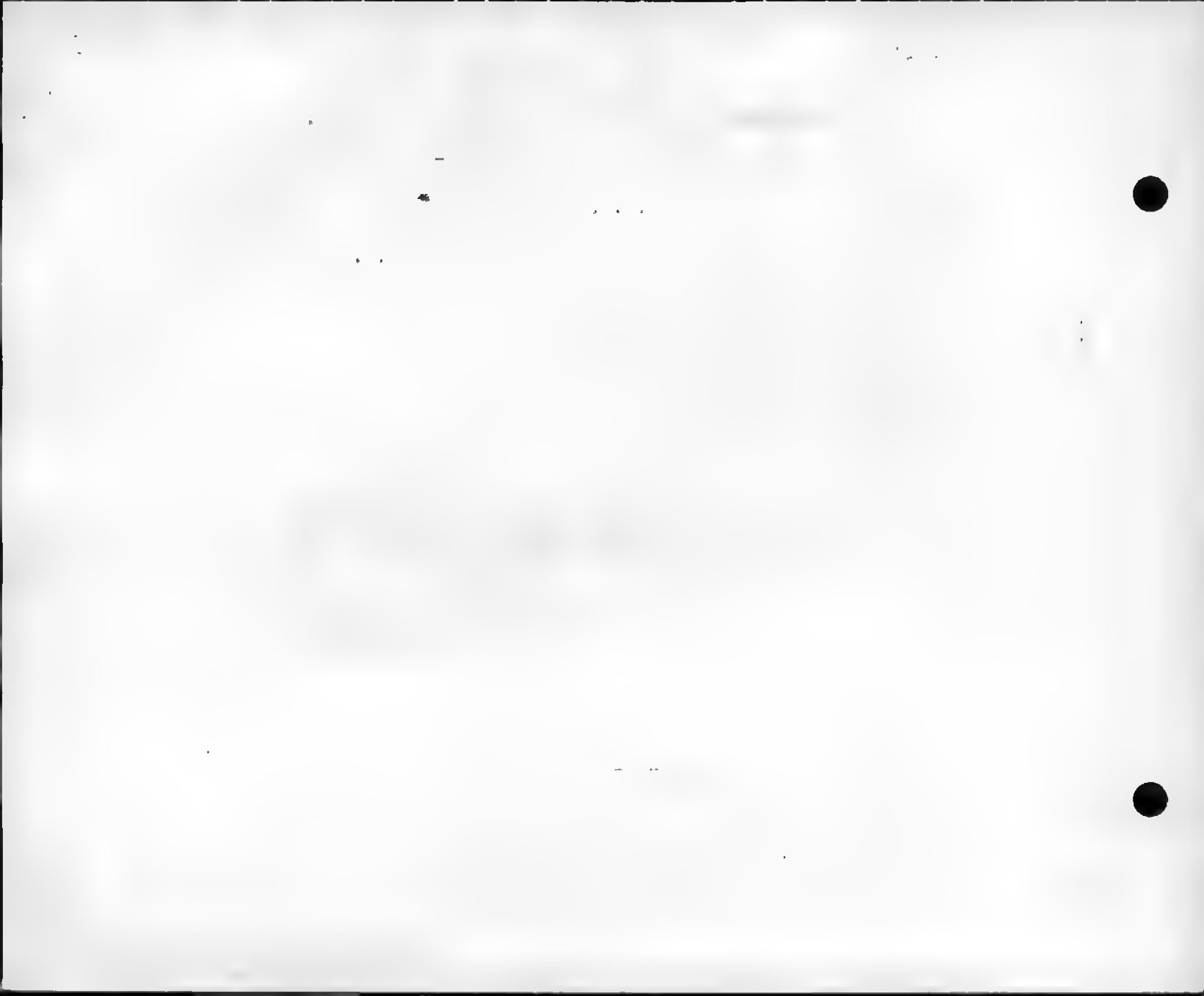
1 DECEASED-NAME (Type or print)				First	Middle	Last	2a. DATE OF DEATH				2b. HOUR		
XXXXX Rosa Virginia XXXXX O'Haro							2 Month 4 Day 69 year				8:00 am		
3 SEX		4 RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.		
female		white		11/28/82			86 YRS		MONTHS		DAYS		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. COUNTY OF DEATH						
Maryland		USA					Carroll		Md.				
10 CITY OR TOWN OF DEATH				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of work life, even if retired.)				12b. KIND OF BUSINESS OR INDUSTRY	
Rural--Sykesville				Springfield State Hospital				housewife					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER			
Md.				Carroll		Middleburg		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		none			
14. FATHER'S NAME				15 MOTHER'S MAIDEN NAME									
First Middle Last Charles E. O'Haro				First Middle Last Fannie Esworthy									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown				16b. SOCIAL SECURITY NO.		17 INFORMANT Address							
no				218-54-3407		Springfield Hospital records, Sykesville, Md.							
1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure												days	
4270 DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last													
(b) DUE TO, OR AS A CONSEQUENCE OF													
(c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Chronic brain syndrome associated with senile brain disease with behavioral reaction.													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B)					
21d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> at home <input type="checkbox"/> at work <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)				21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (X) (this hospital) attended the deceased from 8/24/1967, to 2/4/1969, that (X) (we) last saw the deceased alive on 2/4/1969, and that in (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death													
22b. SIGNATURE												22c. DATE SIGNED	
Naci N. Buyukunsal, M.D.												2/4/69	
22d. PHYSICIAN'S NAME (Type)												22e. ADDRESS	
Springfield State Hospital												Sykesville, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)			
Burial				2-7-1969		Mount Olivet Cemetery				Frederick, Frederick, Md.			
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE					
Robert E. Dailey & Son				Frederick, Maryland				FEB 10 1969					



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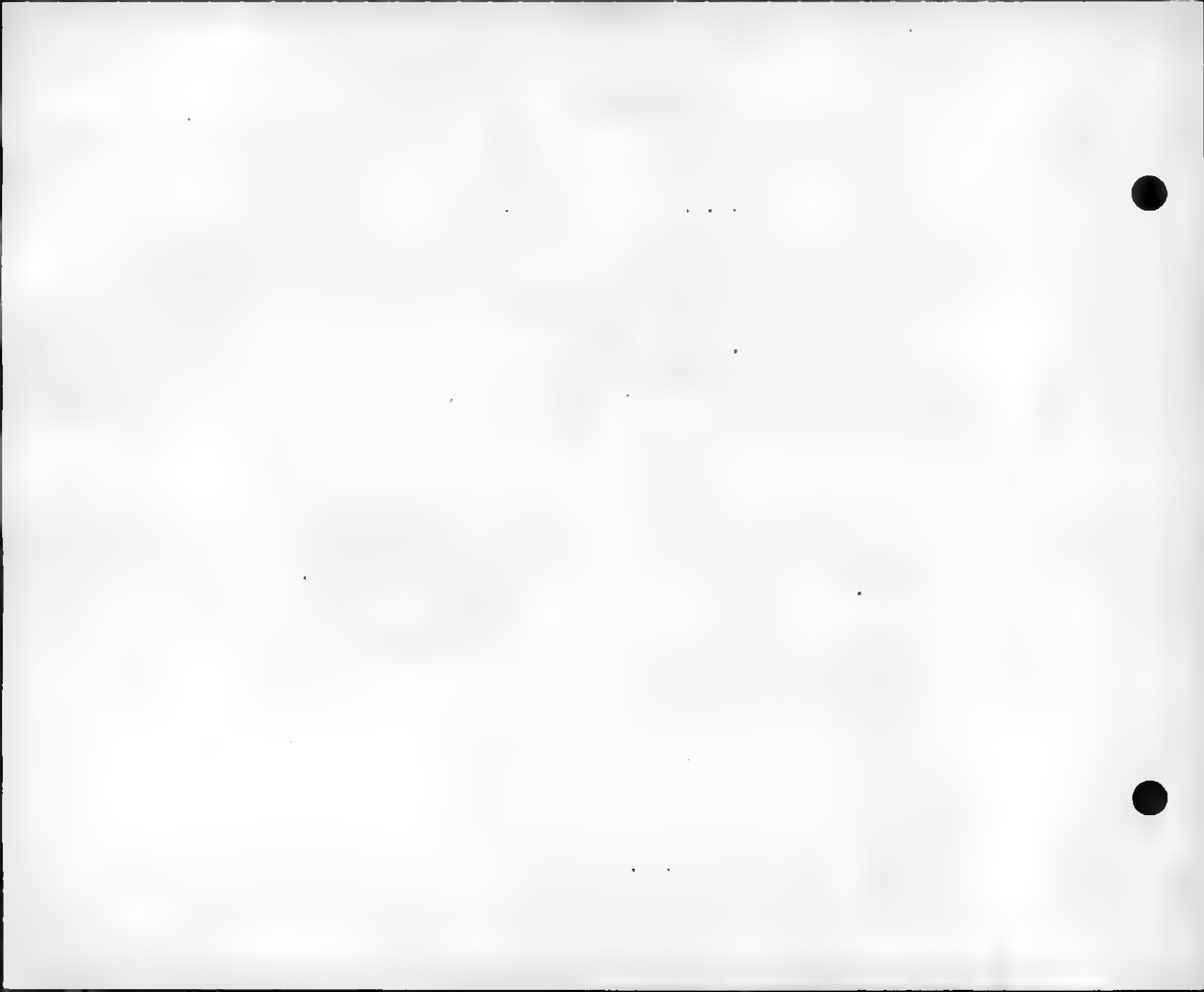
MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) ^{First} Stanley ^{Middle} None ^{Last} Penman						2a. DATE OF DEATH			11. HOUR		
3. SEX ^{Male}						4. RACE ^{White}			5. DATE OF BIRTH ^{Feb.} ¹⁸ ⁶⁹		
7a. BIRTHPLACE (State or foreign country) ^{Maryland}						7b. CITIZEN OF WHAT COUNTRY? ^{Allegany U.S.A.}			6. AGE (in years last birthday) ⁷⁸		
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>						9. COUNTY OF DEATH ^{Carroll}			12. IF UNDER YEAR MONTHS DAYS HOURS MIN.		
10. CITY OR TOWN OF DEATH ^{Sykesville}						11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) ^{Springfield State Hosp}			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) ^{R.H. Brakeman}		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE ^{Maryland}						13b. COUNTY ^{Allegany}			13c. CITY OR TOWN ^{Barton}		
14. FATHER'S NAME ^{John} ^{None} ^{Penman}						15. MOTHER'S MAIDEN NAME ^{Mary} ^{Mackey}			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) ^{No}						16b. SOCIAL SECURITY NO. ^{None}			17. INFORMANT ^{Hospital Records}		
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c))											
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) ^{Pneumonia}											
4123 DUE TO, OR AS A CONSEQUENCE OF ^{Congestive Heart Failure}											
(b) DUE TO, OR AS A CONSEQUENCE OF ^{Cardiovascular Heart Disease}											
(c) ^{Chronic Phrenic Paralysis}											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)											
19a. DATE OF OPERATION											
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED											
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)											
21b. TIME OF INJURY HOUR A.M. Month Day Year 19 ¹² ¹ ¹⁹ ⁶⁹											
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2. Item 18)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>											
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.											
21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from ¹²⁻¹ ¹⁹ ⁶⁹ to ²⁻¹⁸ ¹⁹ ⁶⁹ , that (I) (we) last saw the deceased alive on ²⁻¹⁸ ¹⁹ ⁶⁹ , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE ^{Gracito V. Patricio} DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>											
22d. PHYSICIAN'S NAME (Type) ^{Gracito Patricio}											
22e. ADDRESS ^{Springfield State Hospital}											
23a. BURIAL, CREMATION, REMOVAL (Specify)											
23b. DATE ^{2/21/69}											
23c. NAME OF CEMETERY OR CREMATORY ^{Lanzer Hill Cem.}											
23d. LOCATION (City or Town) (County) (State) ^{Westernport} ^{Alle.} ^{Md.}											
24. FUNERAL DIRECTOR ^{C.J. Boal} ADDRESS ^{Westernport, Md.}											
25a. REC'D BY REGISTRAR ^{FEB 24 1969}											
25b. REGISTRAR'S SIGNATURE ^{Gracito V. Patricio}											



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MARYLAND STATE DEPARTMENT OF HEALTH																							
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																							
CERTIFICATE OF DEATH																							
1. DECEASED-NAME (Type or print)			First EDNA			Middle SEDORA			Last PLUMMER			2a. DATE OF DEATH Month FEBRUARY			Day 6			Year 1969			2b. HOUR 8:45 P		
3. SEX Female			4. RACE Negro			5. DATE OF BIRTH 3-4-04			6. AGE (In years last birthday) 64 YRS.			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS. HOURS MIN.								
7a. BIRTHPLACE (State or foreign country) Maryland			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Carroll Md.														
10. CITY OR TOWN OF DEATH Sykesville			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Springfield State Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife			12b. KIND OF BUSINESS OR INDUSTRY														
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Montgomery			13c. CITY OR TOWN Poolesville			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER Jonesville Road											
14. FATHER'S NAME First William			Middle A.			Last Hall			15. MOTHER'S MAIDEN NAME First Lyles			Middle Black			Last								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No			(If yes give war or dates of service)			16b. SOCIAL SECURITY NO. 577-46-7858			17. INFORMANT Address Records, Springfield State Hospital														
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u>												Days											
4109 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>Severe coronary artery arteriosclerosis</u>												Years											
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Thrombosis of left coronary artery</u>												Minutes											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>CBS associated with cerebral arteriosclerosis, with psychotic reaction. Severe diabetes mellitus.</u>																							
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (At home farm street factory, office building etc)			21f. LOCATION Street or R.F.D. No. City or Town County State																	
22a. I certify that (I) (this hospital) attended the deceased from <u>8-23-66</u> , 19__, to <u>2-5-69</u> , 19__, that (I) (we) last saw the deceased alive on <u>2-5-69</u> , 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																							
22b. SIGNATURE <u>Dr. Antonius Glahn</u> DEGREE												22c. DATE SIGNED 2-7-69											
22d. PHYSICIAN'S NAME (Type) <u>Antonius Glahn, M. D.</u>												22e. ADDRESS <u>Springfield State Hospital</u> <u>Sykesville, Maryland 21784</u>											
23a. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>			23b. DATE <u>2-11-69</u>			23c. NAME OF CEMETERY OR CREMATORY <u>ELIJAH Church Cem.</u>			23d. LOCATION (City or Town) (County) (State) <u>Poolesville Montg. Md.</u>														
24. FUNERAL DIRECTOR <u>George R. Snowden</u> ADDRESS <u>Rockville</u>												25a. REC'D BY REGISTRAR DATE <u>FEB 13 1969</u>			25b. REGISTRAR'S SIGNATURE <u>(Signature)</u>								



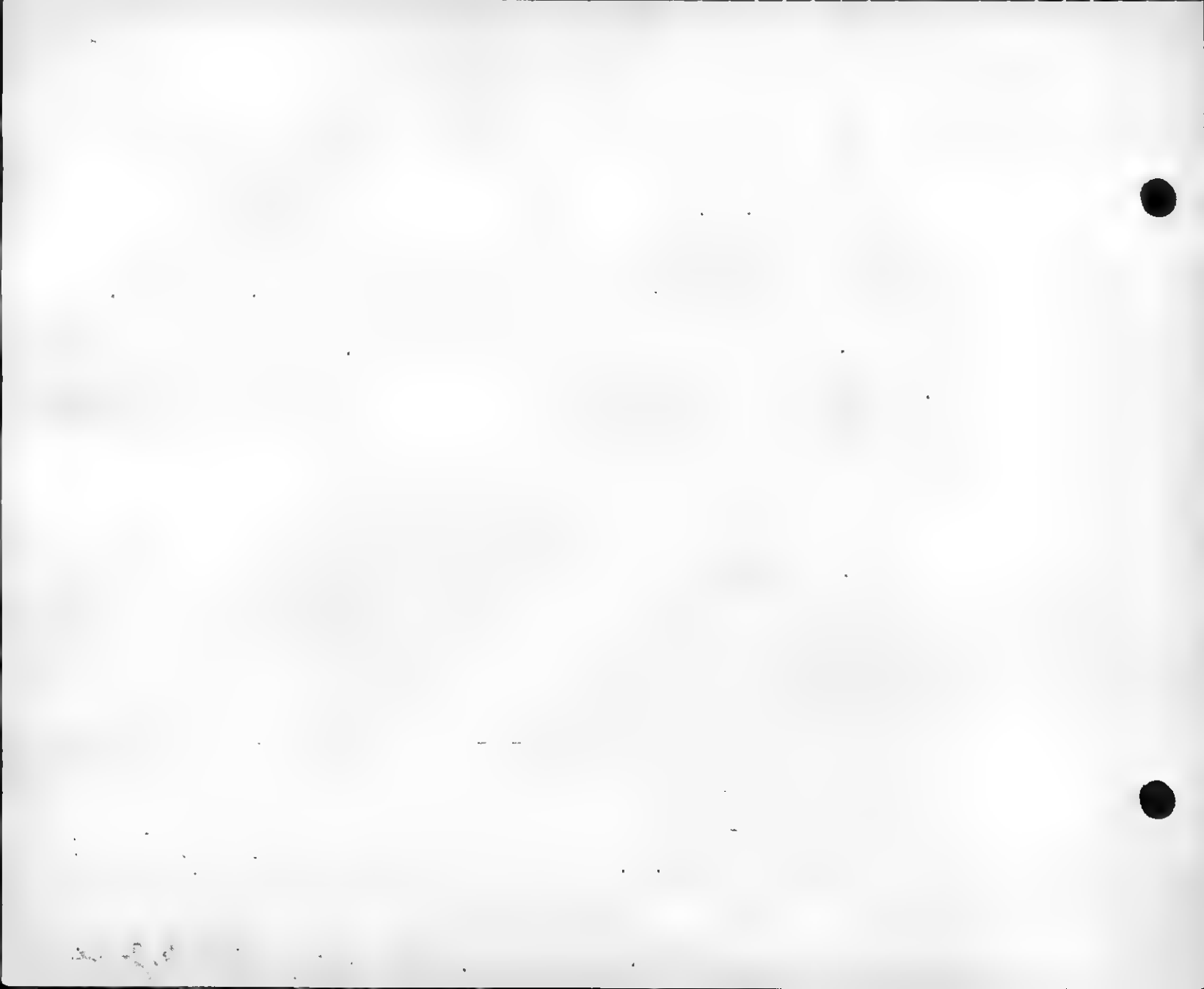
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and to any event, within 72 hours after death.

VR A15
45M - 1

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201														
02266		CERTIFICATE OF DEATH						02262						
1 DECEASED NAME (Type or print)			First		Middle		Last		2a. DATE OF DEATH Month Day Year			2b. HOUR		
WILBUR			ALLEN		ROCKSTROH		FEBRUARY 18, 1969			7:20 P M				
3 SEX			4. RACE		5 DATE OF BIRTH			6 AGE (In years lost birthday)			7 UNDER 1 YEAR MONTHS DAYS		8 UNDER 24 HRS HOURS M N	
Male			White		8-9-1890			78 YRS.						
7a BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH					
Maryland			U.S.A.						Carroll Md.					
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)						12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
Sykesville			Springfield State Hospital						Elevator Operator					
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c CITY OR TOWN			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER		
Maryland			Baltimore City			Baltimore			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			1214 S. Charles St.		
14 FATHER'S NAME			First		Middle		Last		15 MOTHER'S MAIDEN NAME			First Middle Last		
Unk.			Rockstroh						Unk.			Blades		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b SOCIAL SECURITY NO			17 INFORMANT						Address		
Unk.			217-14-1659			Records, Springfield State Hospital								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u>												Jays		
DUE TO, OR AS A CONSEQUENCE OF														
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last												Years		
(b) <u>Pulmonary tuberculosis, active</u>														
DUE TO, OR AS A CONSEQUENCE OF														
(c) <u>Arteriosclerotic cardiovascular disease</u>												Years		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>CBS assoc. with cerebral arteriosclerosis, with psychotic reaction</u>														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION Street or R.F.D. No City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from <u>7-19-65</u> , 19 <u> </u> , to <u>2-16-69</u> , 19 <u> </u> , that (I) (we) last saw the deceased alive on <u>2-16-69</u> , 19 <u> </u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE			22c. DATE SIGNED											
<u>Jose Chapulle</u>			2-19-69											
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS											
Jose Chapulle, M. D.			Springfield State Hospital Sykesville, Maryland 21784											
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)						
Burial			2/22/69		Baltimore Cemetery			Baltimore Maryland						
24. FUNERAL DIRECTOR			25a. REC'D BY REGISTRAR					25b. REGISTRAR'S SIGNATURE						
KRAUSE FUNERAL HOME 1216 S. Charles St.			FEB 20 1969					<u>Charles Judge</u>						

MEDICAL CERTIFICATION



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner along with form PW-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (10)
10M REV. 1/68

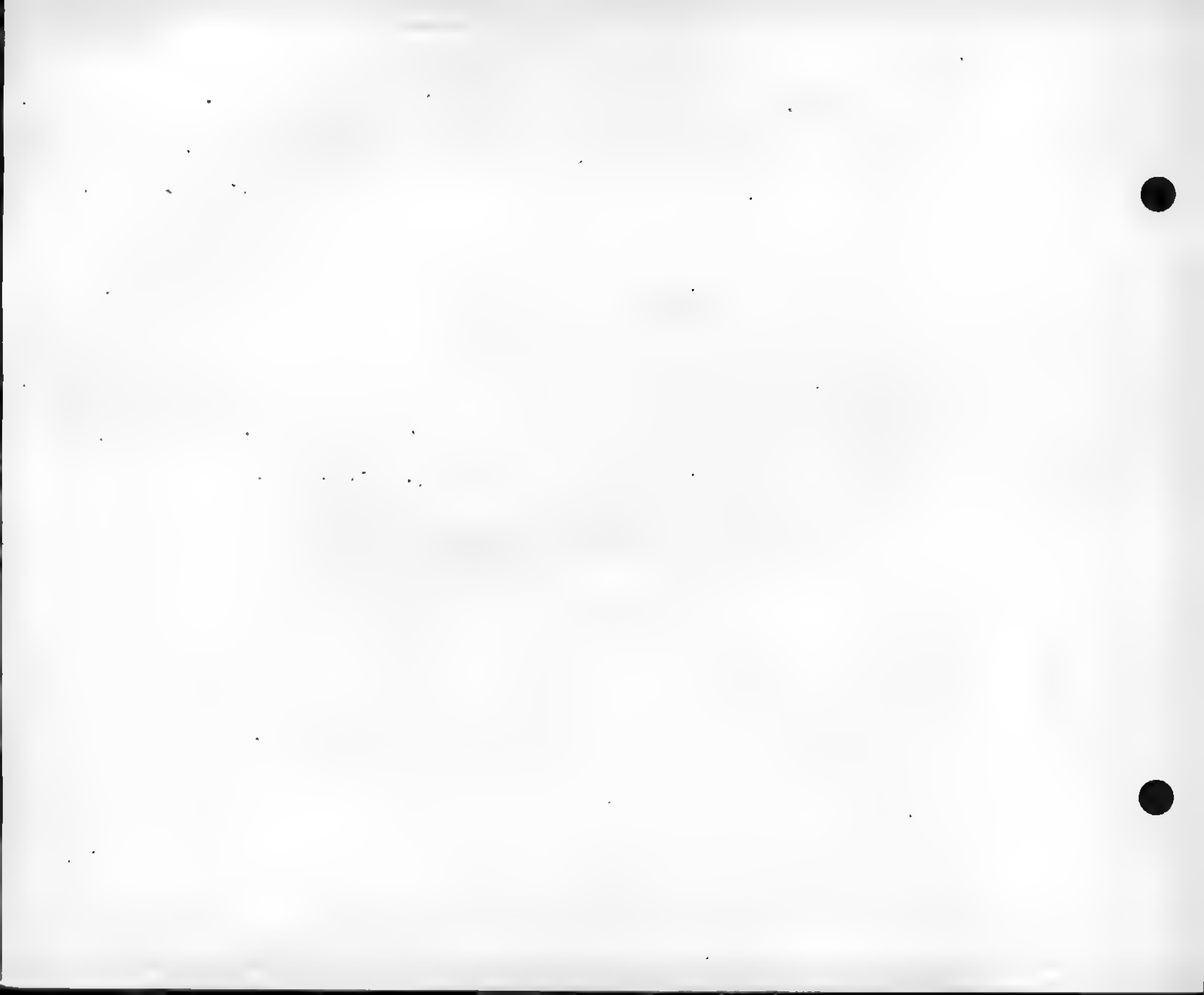
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02267

02263

1. DECEASED-NAME (Type or Print) <i>John F. Schmidt</i>			2a. DATE KNOWN OF ESTI-DEATH MATED <input checked="" type="checkbox"/> Month <i>Feb</i> Day <i>22</i> Year <i>1969</i>			2b. HOUR <i>4:45 p.m.</i>		
3 SEX <i>MALE</i>	4 RACE <i>White</i>	5 DATE OF BIRTH <i>FEB 23, 1902</i>	6 AGE (In years last birthday) <i>66</i> YRS	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS HOURS	2c. DATE PRONOUNCED DEAD <i>Feb 22</i> Year <i>1969</i>	2d. HOUR <i>5:00 p.m.</i>	
7a. BIRTHPLACE (State or foreign country) <i>Md.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Carroll</i>		
10. CITY OR TOWN OF DEATH <i>WESTMINSTER, Md.</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>WASHINGTON ROAD</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life or if retired) <i>FARMER</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>FARMING</i>
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>			13b. COUNTY <i>CARROLL</i>	13c. CITY OR TOWN <i>Westminster</i>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER <i>Bird View Road</i>		
14. FATHER'S NAME First <i>John</i> Middle <i>Michael</i> Last <i>Schmidt</i>				15. MOTHER'S MAIDEN NAME First <i>MARY</i> Middle <i>-</i> Last <i>Bentreys</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>			16b. SOCIAL SECURITY NO. <i>215 16 6735</i>		17. INFORMANT ADDRESS <i>MRS. Viola Schmidt (Westminster, Md.)</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Vascular Accident</i>								<i>20 min</i>
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Cerebral Arteriosclerosis</i>								<i>1 yr.</i>
DUE TO, OR AS A CONSEQUENCE OF (c) _____								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year <i>19</i> P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> HOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <i>Maurice C. Porterfield</i>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED <i>2-22-69</i>		
EXAMINER'S NAME (Type) <i>M.C. PORTERFIELD</i>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS <i>HAMPSTON, CARROLL, Md.</i>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>2-25-69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>New Oakland</i>		23d. LOCATION (City or Town) <i>Sykesville</i>		(County) <i>Md.</i>
24. FUNERAL DIRECTOR <i>Harry W. Haight</i>				ADDRESS <i>Sykesville, Md.</i>		25a. REC'D BY REGISTRAR <i>Charles Judge</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>
DATE <i>FEB 27 1969</i>								

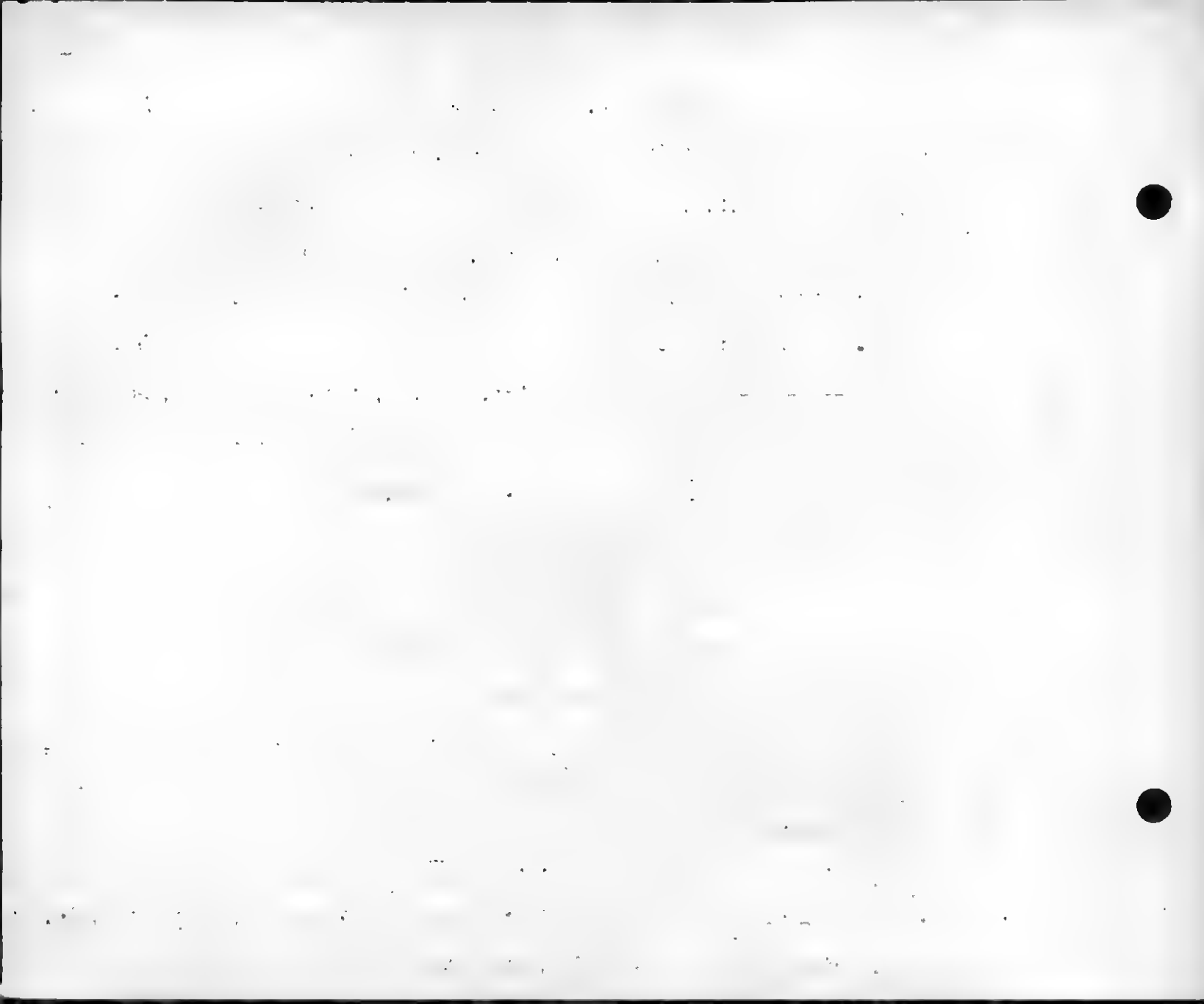


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
30M REV

02268										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										02264																																							
1 DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR																																							
ANN MARIA J. STEEL										Feb Month 6 Day 1969										5:40 PM																																							
3 SEX Female										4. RACE Caucasian										5 DATE OF BIRTH Sept. 16, 1872										6 AGE (In years and months) 90 YRS										IF UNDER 1 YEAR MONTHS DAYS										IF UNDER 24 HRS. HOURS MIN									
7a. BIRTHPLACE (State or foreign country) Maryland										7b. CITIZEN OF WHAT COUNTRY? U.S.A.										8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH Carroll, Md																													
10. CITY OR TOWN OF DEATH Middleburg										11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Brookville Manor Nur. Home										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Homemaker										12b. KIND OF BUSINESS OR INDUSTRY None																													
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland										13b. CITY OR TOWN Frederick										13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										13d. STREET AND NUMBER 901 North Market Street																													
14. FATHER'S NAME First Middle Last Adam Arthur DeVilbiss										15. MOTHER'S MAIDEN NAME First Middle Last Alverdia Lookingbill																																																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No										16b. SOCIAL SECURITY NO ?										17. INFORMANT Address Mrs. Helen B. Young Frederick, Maryland																																							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																																							
PART 1. DEATH WAS CAUSED BY:																																																											
IMMEDIATE CAUSE (a) Cerebrovascular accident																				10 days																																							
DUE TO, OR AS A CONSEQUENCE OF																																																											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																																																											
(b) Cerebral atherosclerosis.																																																											
DUE TO, OR AS A CONSEQUENCE OF																																																											
(c)																																																											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c)																																																											
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																																							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)										21f. LOCATION Street or R.F.D. No. City or Town County State																																							
22a. I certify that (I) (this hospital) attended the deceased from 1967, 19, to Feb 6, 1969, that (I) (we) lost saw the deceased alive on Feb 6, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																																											
22b. SIGNATURE Dr. Caricofe M.D.																				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>										22c. DATE SIGNED 2/6/69																													
22d. PHYSICIAN'S NAME (Type) Dr. Caricofe M.D.																				22e. ADDRESS Carroll County, Maryland																																							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial										23b. DATE 2-10-1969										23c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery										23d. LOCATION (City or Town) (County) (State) Frederick, Frederick Md.																													
24. FUNERAL DIRECTOR Robert E. Dalley & Son																				ADDRESS Frederick, Maryland										25a. REC'D BY REGISTRAR DATE FEB 11 1969										25b. REGISTRAR'S SIGNATURE																			

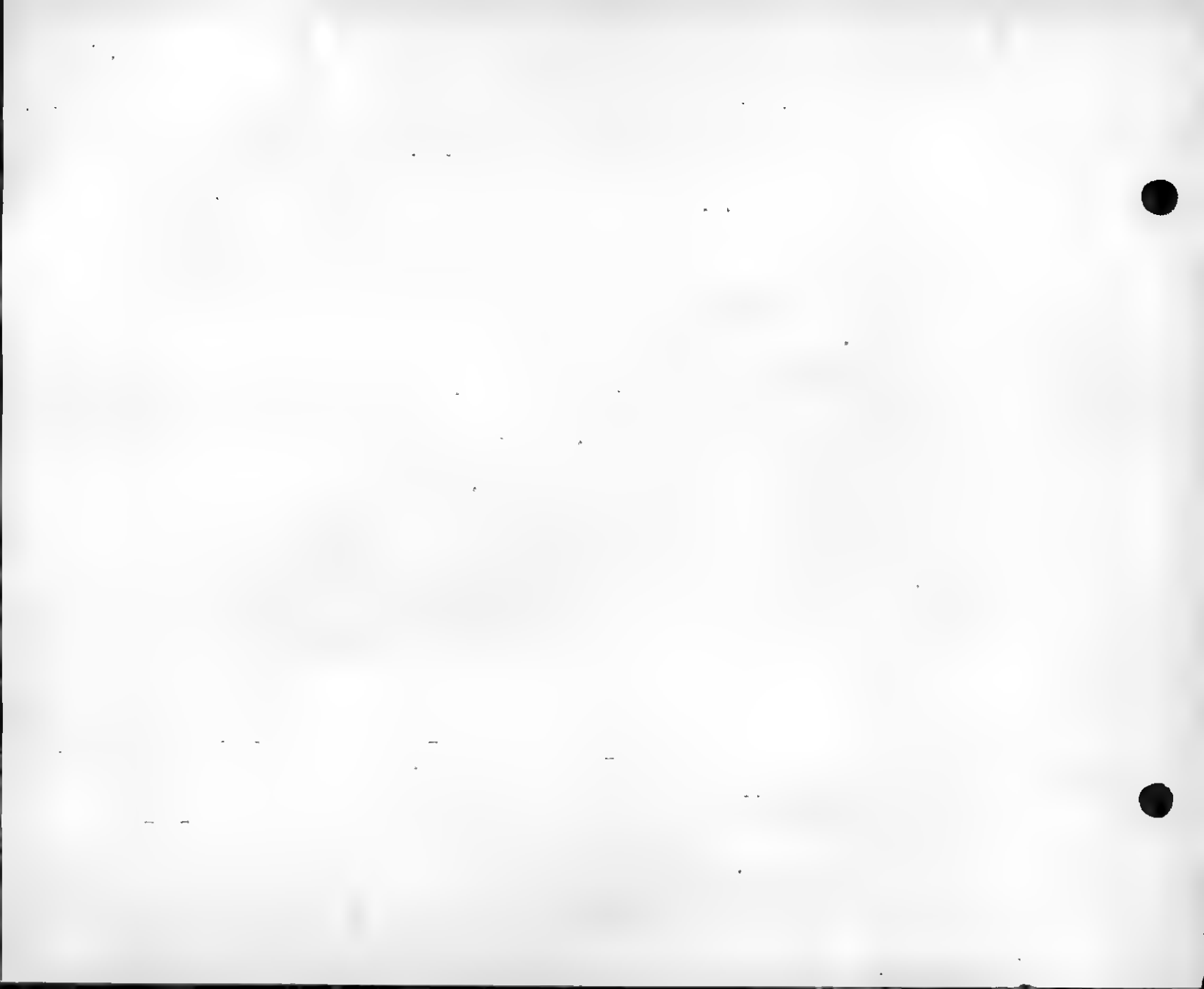


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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 15
45M 11-29

<div>02269</div> <div> <div>1</div> <div>02265</div> </div>											
<div> <div> <div>1 DECEASED-NAME (Type or print)</div> <div>First</div> <div>Middle</div> <div>Last</div> </div> <div>2a DATE OF DEATH</div> <div>2b HOUR</div> </div>											
<div>Richard William Thomas</div>			<div>February 19, 1969</div>			<div>10:50 AM</div>					
<div>3 SEX</div> <div>Male</div>		<div>4 RACE</div> <div>Negro</div>		<div>5 DATE OF BIRTH</div> <div>11-10-05</div>		<div>6 AGE (n years last birthday)</div> <div>63 RS.</div>		<div>7 UNDER 1 YEAR</div> <div>MONTHS</div> <div>DAYS</div>		<div>8 UNDER 24 HRS</div> <div>HOURS</div> <div>MIN</div>	
<div>7a BIRTHPLACE (State or foreign country)</div> <div>Maryland</div>		<div>7b CITIZEN OF WHAT COUNTRY?</div> <div>U.S.A.</div>		<div>8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></div>		<div>9 COUNTY OF DEATH</div> <div>Carroll County Md.</div>					
<div>10 CITY OR TOWN OF DEATH</div> <div>Sykesville</div>		<div>11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)</div> <div>Springfield State Hospital</div>				<div>12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)</div> <div>Farmer</div>		<div>12b KIND OF BUSINESS OR INDUSTRY</div>			
<div>13a USUAL RESIDENCE (Where deceased lived or institution Residence before admission) STATE</div> <div>Maryland</div>		<div>13b COUNTY</div> <div>Montgomery</div>		<div>13c CITY OR TOWN</div> <div>Sandy Spring</div>		<div>13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/></div>		<div>13e STREET AND NUMBER</div>			
<div>14. FATHER'S NAME</div> <div>First</div> <div>Middle</div> <div>Last</div> <div>unk.</div>				<div>15 MOTHER'S MAIDEN NAME</div> <div>First</div> <div>Middle</div> <div>Last</div> <div>Liza Ella Thomas</div>							
<div>16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)</div> <div>None</div>		<div>16b SOCIAL SECURITY NO</div> <div>227-09-8447</div>		<div>17 INFORMANT</div> <div>Address</div> <div>Records, Springfield State Hospital</div>							
<div>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))</div> <div>PART 1. DEATH WAS CAUSED BY:</div> <div>IMMEDIATE CAUSE (a) Hemiplegia, right-sided, due to</div> <div>4337</div> <div>CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost:</div> <div>(b) Cerebral thrombosis, due to</div> <div>DUE TO, OR AS A CONSEQUENCE OF</div> <div>(c) Generalized arteriosclerosis</div> <div>DUE TO, OR AS A CONSEQUENCE OF</div>										<div>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</div> <div>days</div>	
<div>PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)</div> <div>CBS, associated with cerebral arteriosclerosis with behavioral reaction</div>											
<div>19a. DATE OF OPERATION</div>		<div>19b. CONDITION FOR WHICH OPERATION WAS PERFORMED</div>		<div>20a. AUTOPSY?</div> <div>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></div>		<div>20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</div>					
<div>21a ACCIDENT WAS UNDERLYING</div> <div><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (if either, not by medical examiner)</div>		<div>21b. TIME OF INJURY</div> <div>HOUR A.M. Month Day Year</div> <div>P.M. 19</div>		<div>21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)</div>							
<div>21d INJURY OCCURRED</div> <div>While <input type="checkbox"/> Not while <input type="checkbox"/></div> <div>of work <input type="checkbox"/> of work <input type="checkbox"/></div>		<div>21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)</div>		<div>21f LOCATION</div> <div>Street or R.F.D. No.</div> <div>City or Town</div> <div>County</div> <div>State</div>							
<div>22a. I certify that (I) (this hospital) attended the deceased from 6-29-, 1966, to 2-19-, 1969, that (I) (we) last saw the deceased alive on 2-19-1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.</div>											
<div>22b SIGNATURE</div> <div>Octavio A. Ruiz MD</div>				<div>DEGREE</div> <div>ATTENDING PHYS</div> <div>MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/></div>		<div>22c DATE SIGNED</div> <div>2-19-69</div>					
<div>22d PHYSICIAN'S NAME (Type)</div> <div>Octavio A. Ruiz</div>				<div>22e ADDRESS</div> <div>Springfield State Hospital</div>							
<div>23a BURIAL CREMATION, REMOVAL (Specify)</div> <div>BURIAL</div>		<div>23b DATE</div> <div>2-23-69</div>		<div>23c NAME OF CEMETERY OR CREMATORY</div> <div>Sandy Spring Cem</div>		<div>23d LOCATION (City or Town)</div> <div>Sandy Spring</div>		<div>(County)</div> <div>Montg.</div>		<div>(State)</div> <div>Md.</div>	
<div>24 FUNERAL DIRECTOR</div> <div>20492</div>				<div>ADDRESS</div> <div>A. Snowden</div>		<div>25a. REC'D BY REGISTRAR</div> <div>DATE</div> <div>Feb 26 1969</div>		<div>25b REGISTRAR'S SIGNATURE</div> <div>Charles Judge</div>			

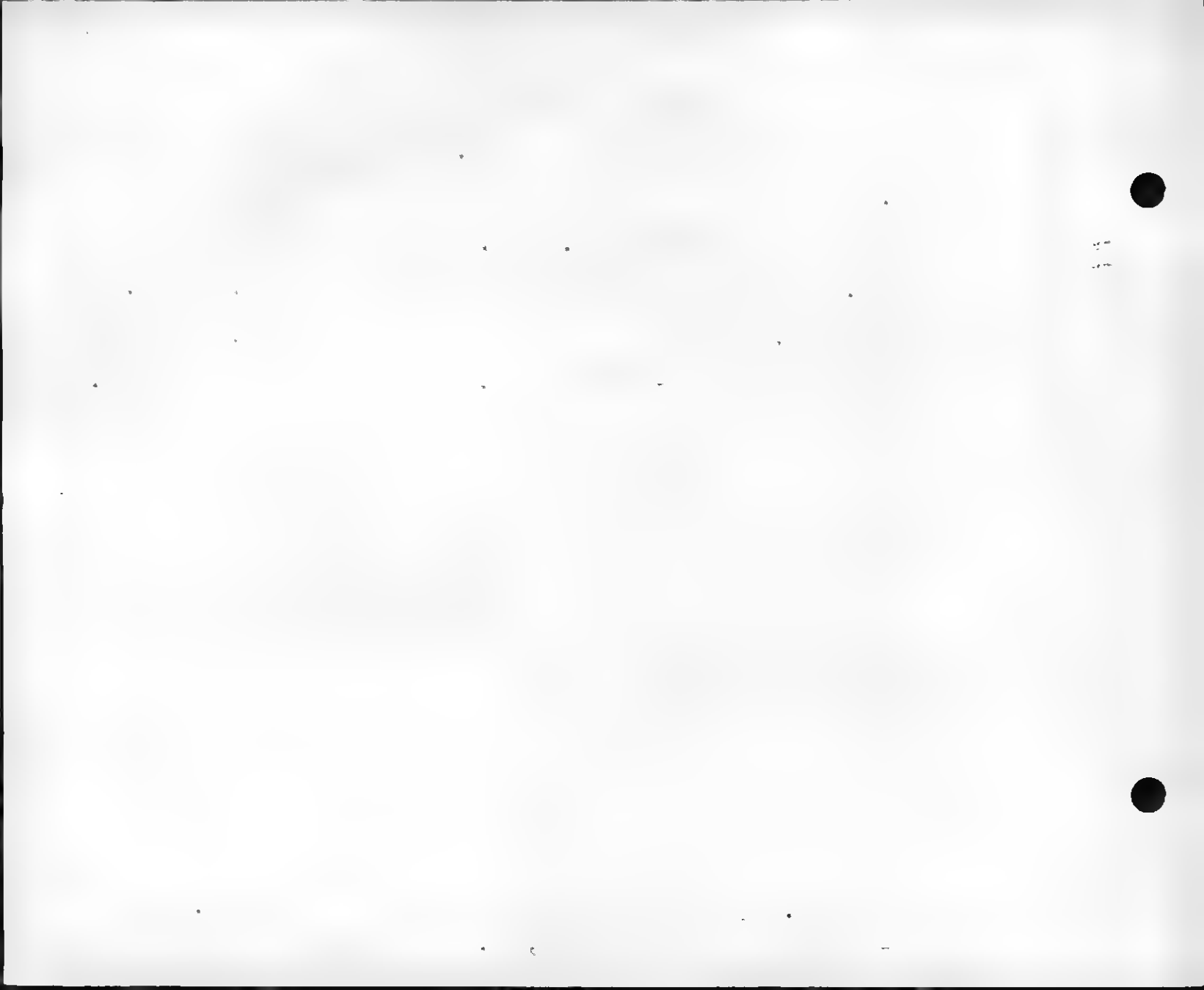


TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15
304A REV. 1-68

02270		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		02266	
CERTIFICATE OF DEATH					
1. DECEASED-NAME (Type or print) William Stanley Thompson			2a. DATE OF DEATH Month 2 Day 7 Year 69		2b. HOUR 6:55 P. M.
3. SEX Male	4. RACE White	5. DATE OF BIRTH Oct. 5, 1918		6. AGE (In years last birthday) 50 YRS.	IF UNDER 1 YEAR MONTHS DAYS
7a. BIRTHPLACE (State or foreign country) Md.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Carroll Md		
10. CITY OR TOWN OF DEATH Westminster		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Carroll Co. Hospt.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Guard	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Carroll	13c. CITY OR TOWN Hampstead	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 253 S. Main St.
14. FATHER'S NAME First William S. Middle Thompson Last 			15. MOTHER'S MAIDEN NAME First Pearl E. Middle (Unknown) Last 		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown Yes (If yes, give number of service) WW 2		16b. SOCIAL SECURITY NO. 212-22-2865		17. INFORMANT Address Mrs. Valerie Thompson Hampstead, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c)) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) RESPIRATORY INSUFFICIENCY 5192 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CHRONIC OBSTRUCTIVE PULMONARY DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) 					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 WEEKS YEARS
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year 19 P.M. 		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State 	
22a. I certify that (I) (this hospital) attended the deceased from 1964 , to 2/7, 1969 , that (I) (we) last saw the deceased alive on 2/7, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Vincent J. Francis Jr. MD				22c. DATE SIGNED 2/7/69	
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS		22f. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Feb. 10, 1969		23c. NAME OF CEMETERY OR CREMATORY Grace Cemetery	
23d. LOCATION (City or Town) Upperco, Md.		23e. (County) 		23f. (State) 	
24. FUNERAL DIRECTOR Tipton - Eline Funeral Home		ADDRESS Hampstead, Md.		25a. REC'D BY REGISTRAR DATE FEB 13 1969	
25b. REGISTRAR'S SIGNATURE J. Charles Judge					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

02271

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02267

CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) First <u>Corothy</u> Middle <u>Caroline</u> Last <u>Tornow</u>			2a. DATE OF DEATH Month <u>2</u> Day <u>1</u> Year <u>69</u>		2b. HOUR <u>11a</u> M
3 SEX <u>Female</u>	4. RACE <u>White</u>	5. DATE OF BIRTH <u>March 5, 1926</u>		6. AGE (In years last birthday) <u>42</u> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (State or foreign country) <u>Maryland</u>	7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH <u>Carroll</u> Md.		
10. CITY OR TOWN OF DEATH <u>Sykesville, Md.</u>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Springfield State</u>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <u>Typist</u>	
12b. KIND OF BUSINESS OR INDUSTRY <u>Gov't.</u>					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>Maryland</u> 13b. COUNTY <u>Baltimore</u>		13c. CITY OR TOWN <u>Baltimore</u>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <u>5813 Falkirk Rd.</u>	
14. FATHER'S NAME First <u>Ernest</u> Middle <u></u> Last <u>Tornow</u>		15. MOTHER'S MAIDEN NAME First <u>Lary</u> Middle <u>C</u> Last <u>Koebl</u>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO <u>220-30-14603</u>		17. INFORMANT Address <u>Springfield State Hospital, Sykesville, Md</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> <u>486X</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Days</u>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Schizophrenia Reaction, chronic undiff type</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>Aug. 4, 1963</u> , to <u>Feb. 1, 1969</u> , that (I) (we) last saw the deceased alive on <u>etc. 1, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (and others) view the body after death.					
22b. SIGNATURE <u>Dr. Antonius Glahn</u>		DEGREE <u>MD</u>		ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>	
22d. PHYSICIAN'S NAME (Type) <u>Dr. Antonius Glahn</u>		22e. ADDRESS <u>Springfield State Hosp. Sykesville, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>2-3-69</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer</u>	
23d. LOCATION (City or Town) (County) (State) <u>Balto. Md.</u>					
24 FUNERAL DIRECTOR <u>H.W. Jenkins & Sons Co.</u>		ADDRESS <u>4205 York Rd.</u>		25. REC'D BY REGISTRAR <u>FEB 4 1969</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					



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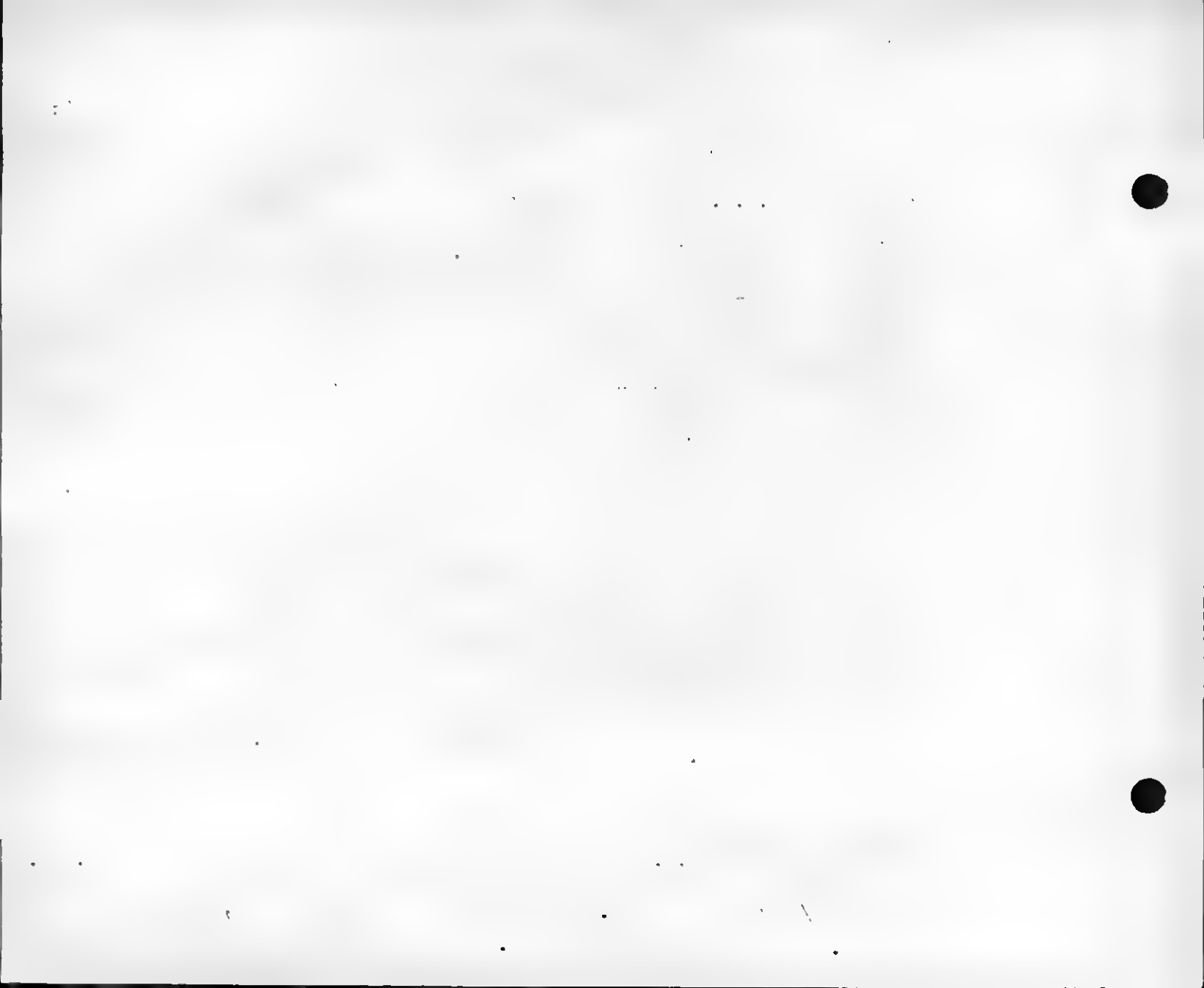
MARYLAND STATE DEPARTMENT OF HEALTH															
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201															
CERTIFICATE OF DEATH															
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR						
Mabel Lucy Tuke						Feb Month 3 Day 1969 Year			10 00 P.M.						
3 SEX		4. RACE		5. DATE OF BIRTH			6 AGE (In years last birthday)		7 UNDER 1 YEAR		7 UNDER 24 HRS.				
Female		White		Oct 2 - 1884			84 YRS.		MONTHS DAYS		HOURS MIN.				
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH						
Illinois			U.S.A.						CARROLL Co			Md.			
10. CITY OR TOWN OF DEATH				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)				12b. KIND OF BUSINESS OR INDUSTRY			
Holbrook				CHAPEL HILL NURSING HOME				AT HOME							
13a. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) STATE				13b. COUNTY				13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
VIRGINIA				Richmond				YES		NO		4822 W. SEMINARY AVE.			
14. FATHER'S NAME			15 MOTHER'S MAIDEN NAME												
First Middle Last			First Middle Last												
William F. Tuke			Julia Hayden												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)				16b. SOCIAL SECURITY NO.				17. INFORMANT				Address			
No				-				Isabel T. Thomas - 15 D Cross Keys Rd # 21310							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY:															
IMMEDIATE CAUSE (a) COMPLETE OBSTRUCTION COLON.												8 HRS.			
1598 DUE TO, OR AS A CONSEQUENCE OF															
(b) METASTATIC CARCINOMA COLON												1 YR.			
DUE TO, OR AS A CONSEQUENCE OF															
(c) CARCINOMA PELVIC ORGANS												4 YRS.			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)															
ASCVD.															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
			HOUR A.M. Month Day Year P.M. 19												
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State									
22a. I certify that (I) (this hospital) attended the deceased from JAN 19 68 to 2-3 19 69, that (I) (we) lost saw the deceased alive on 2-3-1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE						DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED					
J. V. Howard, Jr. MD										2-4-69					
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS									
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)						
Cremation			2-5-69			Loudon Park Crematory			BALTIMORE, Md.						
24. FUNERAL DIRECTOR						ADDRESS		25a. RECORD BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
William P. Wynn						4601 Lett Hgts. Ave. 21204		FEB 7 1969		Charles Judge					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR A
SIDNEY			BENJAMIN			TURNER			Month 2 Day 24 Year 69 7:00 PM
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS
Male		Negro		11/08/1894			74 YRS.		IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		
Maryland			U.S.A.				Carroll Md		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
Sykesville			Springfield State Hosp.			Porter			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER
Maryland			---		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1117 Carey Street
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
JOHN			TURNER			POLLY DESCHILDS			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
no			212-10-2143		Hospital Records				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebrovascular thrombosis									days
DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerosis (generalized)									yrs.
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
CBS associated with cerebral arteriosclerosis with psychotic reaction									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME FARM STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (he) (this hospital) attended the deceased from March 16, 1965, to Feb. 24, 1969, that (he) (we) last saw the deceased alive on Feb. 24, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (he) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Suha Ozgun. DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>								22c. DATE SIGNED 2/24/69	
22d. PHYSICIAN'S NAME (Type) Suha Ozgun, M.D.								22e. ADDRESS Springfield State Hospital, Sykesv., Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		2/27/69		Mt. Calvary		Baltimore, Maryland			
24. FUNERAL DIRECTOR ADDRESS Charles R. Law, 802 Madison Ave.						25a. REC'D BY REGISTRAR DATE FEB 26 1969		25b. REGISTRAR'S SIGNATURE [Signature]	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

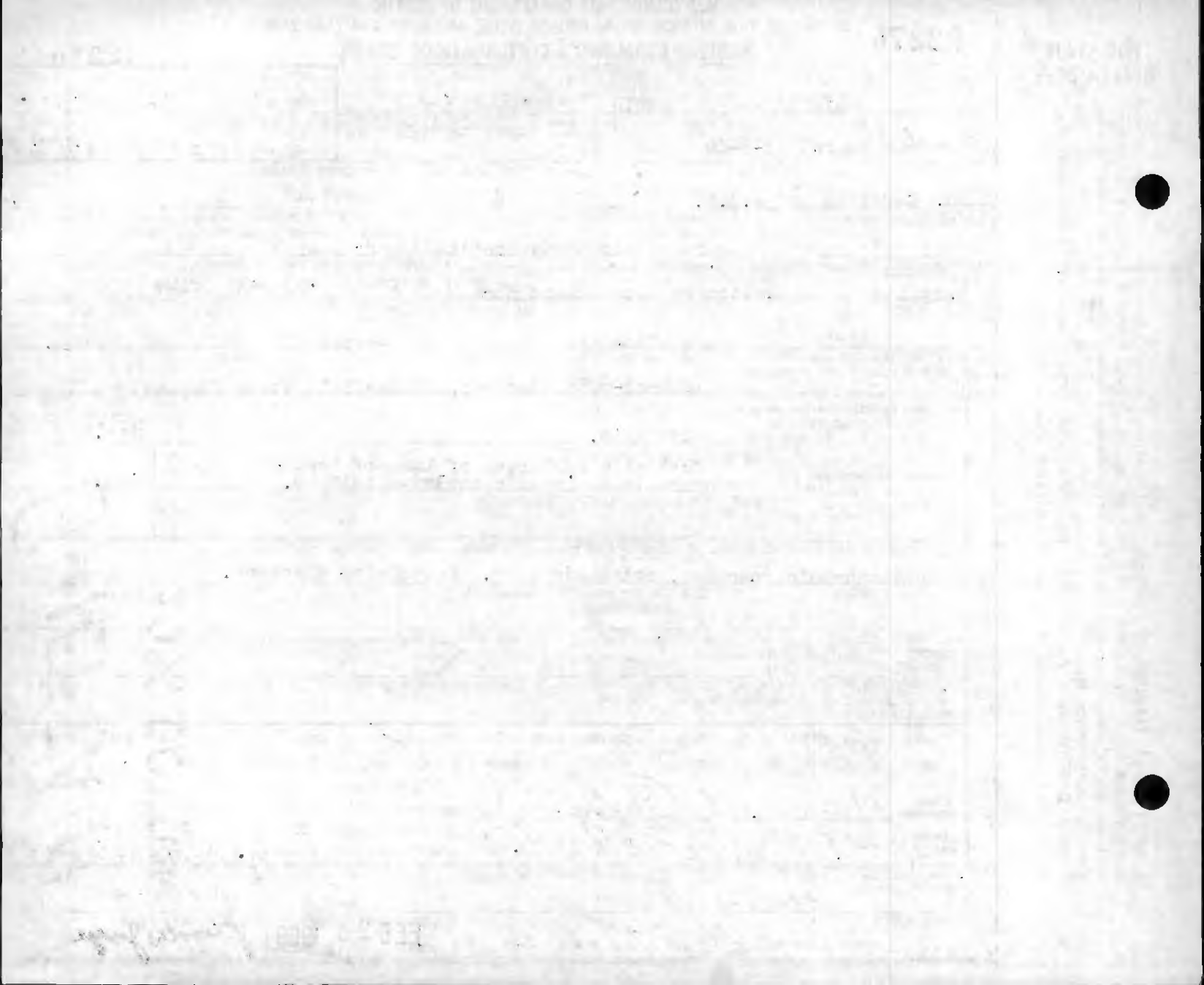
02274

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02270

1. DECEASED-NAME (Type or Print)		First		Middle		Last		2a. DATE KNOWN OF ESTI- DEATH MATED <input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year				2b. HOUR			
LILLIE		RUTH		WELLS				Feb. 21 1969				12:45 PM			
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD Month Day Year				2d. HOUR		
Female	Negro	7-5-24		44 YRS.					Feb. 21 1969				12:45 PM		
7a. BIRTHPLACE (State or foreign country)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH			
South Carolina				U.S.A.								Carroll Md.			
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b. KIND OF BUSINESS OR INDUSTRY			
Sykesville				Springfield State Hospital				Housewife							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE				13b. COUNTY				13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
Maryland				Baltimore City				Baltimore				753 Lake Drive			
14. FATHER'S NAME				First		Middle		Last		15. MOTHER'S MAIDEN NAME				First Middle Last	
Early				Summers						Bertha				Jones	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b. SOCIAL SECURITY NO.				17. INFORMANT ADDRESS							
No				251-22-6055				Records, Springfield State Hospital							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia.</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } <u>Occlusion of larynx of base of tongue</u> (b) <u>probably during a convulsive seizure.</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Schizophrenic reaction, catatonic type. Convulsive disorder.</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
2952												mins.			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												mins.			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> HOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE <u>Maurice C. Porterfield</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED <u>2/22/69</u>							
EXAMINER'S NAME (Type) <u>M.C. PORTERFIELD, M.D.</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				ADDRESS (Street, city, town, or county) <u>HANDSTEAD, MD</u>							
23a. BURIAL, CREMATION REMOVAL (Specify)				23b. DATE <u>2/27/69</u>		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State) <u>COLUMBIA S.C.</u>					
24. FUNERAL DIRECTOR <u>Marvin A. Hays</u>				ADDRESS <u>638 N. Green St</u>				25. REC'D BY REGISTRAR DATE <u>FEB 26 1969</u>				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																							
MEDICAL EXAMINER'S CERTIFICATE OF DEATH																							
1. DECEASED NAME (Type or Print)			First		Middle		Last		2a. DATE KNOWN OF ESTI-DEATH MATED <input checked="" type="checkbox"/> Month Day Year		2b. HOUR												
CHERYL			LESLEY		ZEIGLER				19		M												
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD											
female		white		Dec. 16, 1968		YRS. 2 7		MONTHS 2 DAYS 7		HOURS MIN		2d. HOUR											
												8:30 A.M.											
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH														
Maryland			U.S.A.						Carroll			Md.											
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b. KIND OF BUSINESS OR INDUSTRY											
Manchester				14 N. Main St.																			
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE						13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13e. STREET AND NUMBER													
Maryland						Carroll		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		14 N. Main Street													
14. FATHER'S NAME			First			Middle			Last			15. MOTHER'S MAIDEN NAME			First								
John			W.			Zeigler						Evelyn			Rossman								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b. SOCIAL SECURITY NO.				17. INFORMANT				ADDRESS											
				--				John W. Zeigler				Manchester, Md.				14 N. Main St.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Interstitial Pneumonitis (SDII)</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?															
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>															
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)															
				19																			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No.				City or Town				County				State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED									
ACTUAL SIGNATURE <u>Werner U. Spitz</u>												M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		2/18/69							
EXAMINER'S NAME (Type) Werner U. Spitz, M.D.												DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		ADDRESS (Street, city, town, or county)									
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)											
burial				2/20/69				Evergreen Memorial Gardens				Finksburg, Md.											
24. FUNERAL DIRECTOR								ADDRESS				25a. RECEIVED BY REGISTRAR				25b. REGISTRAR'S SIGNATURE							
J. J. Meyer Jr., Westminster, Md.												FEB 21 1969											

1983

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION

DATE

RECEIVED

FILED

1983

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION